

REVIEW ARTICLE
CITATION
LITERATURE

Notes

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Book Reviews

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Events and Comments

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

As a reviewing and abstracting journal, *Rehabilitation Literature* identifies and describes current books, pamphlets, and periodical articles pertaining to the care, welfare, education, and employment of handicapped children and adults. The selection of publications listed and their contents as reported is for record and reference only and does not constitute an endorsement or advocacy of use by the National Society for Crippled Children and Adults.

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Books for review and correspondence relating to feature articles and other editorial matters should be addressed to the editor. He will welcome your suggestions.

REHABILITATION LITERATURE

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Collecting Walking Canes

THE COLLECTING of walking canes is a fascinating hobby. Private collections of canes usually average from 25 to 50 sticks but often run into the hundreds. The hobbyist's interest in a particular cane will center on its origin, the manner in which it was obtained, the material of which it is made, or the history of its former ownership. The cane collector may have inherited the object of his pride, received it as a gift, or made it himself.

An unofficial cane census for the United States taken not many years ago revealed that there are

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more than 5,000 canes in private collection, more than 10,000 in museums, and several million in actual daily use. No doubt the number has increased considerably since the estimation. Of course, canes are most helpful to persons temporarily or permanently disabled; but the universal appeal of the walking cane lies in its leisure use.

The word "cane," incidentally, was first applied to the walking stick about 1540, when a cane was made, "garnished with gold having a perfume container in the top" as well as other conveniences. Many centuries before there were evolved from the cave man's club different staves, from 5 to 6 ft. in length, including the shepherd's staff for guiding and directing straying sheep, the pastoral staff which served as an emblem of episcopal authority, and the pilgrim's staff, with a knob placed in the middle for a grip. Gradually, the length of the staff was reduced so that the holder could grip it at the top, and as a result

cane makers began to make attractive handles of porcelain, ivory, and such costly metals as gold and silver.

Next the inventive cane makers devised conveniences to be concealed within the handles, such as weapons, spectacles, and perfume and medicine bottles. Sword or dagger canes found immediate favor with some sportsmen, as did gun or pistol canes. The decanter cane, which had wide appeal, was hollow inside and fitted with a glass tube in which a quart of liquor could be stored. From County Wicklow in Ireland came the shillelagh, a blackthorn sapling with a crooked root-knot for the grip, ornamented with a picturesque array of wart-like lumps.

Every country on earth has an indigenous cane. An artistically carved olive wood cane, with a camel's head for a handle, comes from Turkey. France has a cane of woven grass; Scotland, a thistle cane; Switzerland, a horn-and-hoof cane representing an Alpine goat; the West Indies, a lemon wood cane; the Philippines, a cane made of bones; and Cuba, a cane of shark's vertebrae. In certain remote regions of Africa, the tribal chieftain's cane is made with a large ball for the grip. Legend has it that the ball represents the most the chieftain can get into his mouth; hence, the bigger the ball the greater the chieftain. In the United States there are canes with handles that represent the faces of well-known persons; for example, Will Rogers, Franklin D. Roosevelt, William Jennings Bryan, William McKinley, and even William Shakespeare.

Robert Ripley, the famous creator of "Believe It or Not," was one of the best-known collectors of canes. While his personal collection was not the largest in the world, it contained many rare and exotic items. The Ripley collection included a cane made from the rib of a whale; a violin cane, probably the most unusual of all, which contained a playable

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Article of the Month

Special Education Problems in Western Europe

Wallace W. Taylor, Ph.D.

and

Isabelle Wagner Taylor, Ph.D.

About the Authors . . .

Wallace W. Taylor is Professor of Education at the State University College for Teachers in Albany, N.Y. Isabelle Taylor is chairman of the Department of Psychology at Russell Sage College, Troy, N.Y. Both have been long active in education and teacher training—social studies being the focus of interest of the former and child and adolescent psychology and the psychological adjustment of the physically handicapped the center of interest of the latter. Wallace Taylor received his master's and doctoral degrees from the State University of Iowa and his wife Isabelle received hers from Ohio State University.

The opportunities for the handicapped child to obtain an education are much greater in the United States and in Canada than in most of the countries of Western Europe. Although there is great variation in the programs of services offered on this side of the Atlantic, there is even greater variation in the services found in European countries. This is understandable in view of the wider differences there in geography, economic conditions, culture, and language.

The need to provide instruction and printed materials in more than one language is a basic problem. Belgium has both the French and Flemish languages. Finland has a small Swedish-speaking minority, and Switzerland has four different language groups—German, French, Italian, and an archaic Romanish. Yugoslavia faces an additional complication—besides the three major languages of Slovenian, Macedonian, and Serbo-Croatian, there are the two alphabets, Latin and Cyrillic.

Case Finding and Reporting

A fundamental problem in most European countries is the determination of the dimensions of needs by means of accurate statistics concerning the number of children in each disability category. Efforts to develop registers in the United States have not been entirely satisfactory. However, together with the growing number of studies of incidence concentrated in various geographic areas, registers are providing a basis for the realistic estimates needed for program planning. Neither of these approaches—the central register or the regional survey—is as well developed in Europe. For example, a study of the incidence of disability in children in the Province of Madrid (total population over 2 million), reported in an official publication, included only *three* children with epilepsy in the province.

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Half the European countries have laws requiring the reporting of disability in preschool and school-age children, but, in some, these laws are not rigidly enforced, partly because many physicians have regarded such reporting as just additional paper work. This is particularly true when facilities are not adequate for treatment of the cases reported.

Fortunately, data are becoming increasingly available from a variety of sources, even though the aggregate information is still incomplete. Family physicians and mid-

This article, written especially for Rehabilitation Literature, is a summary of a two-year study carried out on a volunteer basis by the authors under the auspices of the International Society for the Welfare of Cripples and of the International Union for Child Welfare. The study had the endorsement of UNESCO and financial support from the World Rehabilitation Fund, the Association for the Aid of Crippled Children, the Easter Seal Research Foundation of the National Society for Crippled Children and Adults, and The National Foundation.

The authors spent 10 months doing field work for the study in Austria, Belgium, Denmark, England and Wales, Finland, France, West Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Northern Ireland, Norway, Poland, Portugal, Scotland, Spain, Sweden, Switzerland, and Yugoslavia.

A series of articles dealing with special education in a number of individual countries has been appearing in the journal Exceptional Children. The complete report is scheduled for publication by the International Society for the Welfare of Cripples later this year.

wives now report congenital abnormalities more frequently. Parents are more willing to report cases when there is some prospect that the condition can be remedied. Nationwide examinations for tuberculosis have often turned up other disabling conditions. Clinical teams of maternal and child welfare centers in countries like Austria and Norway also do excellent case-finding service. All the countries surveyed with the exceptions of Italy, Spain, and Portugal report that they now have laws providing for compulsory physical examination of all new school enrollees. When these laws become fully implemented, reliable data should be available regarding the number of handicapped children in each nation and, more important, the medical and educational services needed by such children.

In many countries, leaders in special education say that the importance of nation-wide data is still not widely understood and that, while each country has a central bureau of statistics, local authorities frequently do not

report available data to it. In most of the countries in Western Europe there is a trend toward defining handicaps in general rather than specific terms and toward making children eligible for special education if they can benefit. Medical and educational advances are steadily shrinking the number judged incapable of benefiting from special education; school attendance policies reflect this new situation. Where specific definitions are written into law, administrators tend to interpret the laws so as to permit maximum benefits to the individual. Where insistence on rigid definitions does exist, it is now really based on the lack of special school facilities and thus becomes in effect a screening device for apportioning a few educational opportunities among a large number of children who could learn if given the chance.

Organization and Administration

Many special education problems in Western Europe relate to the administration and organization of services. More effective cooperation is needed among the various governmental agencies serving the handicapped child, such as the ministries of education, health, and social welfare. Responsibility for administration is usually divided among these ministries at the national level, with corresponding departments often administering programs at the provincial and communal levels. Still other ministries may be involved, such as the Ministry of Justice in Greece, Ministry of Labor and National Insurance in Northern Ireland, and the National Pensions Board and the Employment Board in Sweden.

This division of responsibility reflects the historical development of programs for the handicapped. Placing special education under the Ministry of Social Welfare resulted from the initial welfare concept of community obligations to the handicapped, whereas the tendency to shift special education to the Ministry of Education indicates the increasing emphasis on the provision of education. In some cases cooperation among ministries is complicated by the tendency to keep the provisions for the blind and deaf within the Ministry of Social Welfare while giving the Ministry of Education responsibility for programs dealing with those in other disability categories that have more recently had special consideration and therefore have not been traditionally assigned to the Social Welfare ministry.

More effective cooperation is needed not only among the governmental agencies themselves but also between these agencies and the numerous voluntary organizations serving the handicapped. As in the United States, dedicated individuals and groups in every European country have taken the initiative in providing the historical sequence of custodial care, medical treatment, and now educational services for handicapped children.

In some countries the national government has grad-

ually taken over more and more of these services, but in other countries, such as France and Belgium, some of the voluntary societies, including religious organizations, are frequently reluctant to relinquish their traditional responsibility for certain groups. This further complicates efforts to develop a coordinated program. It also creates special problems, as in the fractioning of services when a handicapped pupil must be placed in school on the basis of sex and religion as well as his special needs caused by his disability. This is exemplified in the three separate schools considered necessary in Switzerland for 100 mentally normal blind children—one for Protestant German-speaking children, a second for Protestant French-speaking children, and a third for Catholic children, which holds classes in three languages. This can be further complicated by the tradition of separating boys and girls found in many countries such as Belgium, Germany, and France.

Voluntary and public efforts on behalf of the handicapped can be coordinated to the advantage of all concerned. Such coordination is certainly not complete in the United States, but the level of coordination thus far reached demonstrates both the values and feasibility of such coordination. Some European countries are moving in this direction, but many have far to go.

In every country the administration of special education services also involves more adequate provision of instruction for children in rural and remote areas. Problems may be minimal, as in highly concentrated areas in England, or particularly acute, as in the case of an island in Greece connected with the mainland only by a two-day boat trip or an isolated valley in the mountains of northern Italy where only one narrow, rough road links the inhabitants with communities outside their mountain setting. As in our own country, specially trained personnel tend to become concentrated in large population centers. In Poland and Yugoslavia to offset this, larger living quarters are offered as inducement to recruit teachers for smaller towns and rural areas.

Expanded opportunities are needed for handicapped youngsters able to profit from education on the secondary and university levels. Most European countries consider they have discharged their responsibilities for the special education of handicapped children if an elementary education and some vocational instruction are provided. England's grammar schools for handicapped youths of secondary school age are a relatively recent extension of services in that country. Usually the handicapped youngster who does go beyond elementary and purely vocational training is expected to attend a regular school, sometimes with a little supplementary help such as a reader for blind students. In France, only about 20 blind students enroll each year in university courses.

Another outstanding need in Europe is an adequate supply of special equipment and appliances, such as

prostheses, audiometers, hearing aids, films, recording devices, and electric typewriters. In contrast to the United States, where there is more technical equipment than trained personnel, Europe has a large potential source of special education personnel but a serious shortage of technical supplies. It was reported, for example, that in all of Poland there was only one audiometer. Yugoslavia desperately needs hearing aids; some have been supplied by the United Nations International Children's Emergency Fund (UNICEF), but, since they cannot expect this agency to supply all the needed equipment, the Yugoslavs are trying to overcome technological difficulties in manufacturing their own. The equipment in special schools in most European countries would seem very limited and sometimes even antiquated to observers familiar with special programs in the United States and Canada.

A further need in European special education is the expansion of the kindergarten program for handicapped children. Special educators in Europe recognize that the education, particularly of blind and deaf children, needs to begin as early as possible, and residential institutions for the blind and for the deaf are adding preschool departments. These are usually on a residential basis. A variation of this practice occurs in England, where there is a group of residential "Sunshine Nursery Schools" for blind children. Even before blind or deaf children come to kindergarten or nursery school, however, they need special help from their parents. This help is not possible without some kind of program of parent education. This is now provided in only a few countries by means of an itinerant social worker, parent consultations in the special schools, or summer courses attended by both the mother and the child. The latter courses are more frequently available for parents of deaf than of blind children.

Financing

One of the greatest problems facing special educators in many countries is the securing of adequate financial support for present and future programs. In developing more effective relationships between voluntary and government groups, European countries have followed a pattern quite different from that in the United States. Here there is no governmental support on the state or national level for voluntary efforts for the handicapped; in Europe there is a general tendency for the national government to subsidize schools or programs of voluntary groups at least in part, by paying teachers' salaries, providing buildings and grounds, or paying the pupils' maintenance costs. Standards governing the physical plant and instruction are usually specified and are enforced by some system of inspection.

It is particularly difficult to develop public support for educational programs in countries where unemployment is chronic and where even the laws for compulsory school attendance of normal children are poorly enforced. The lack

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of enforcement may be caused by a lack of facilities to provide education for all children of school age. In the fall of 1958 over 800,000 Spanish children of school age could not attend school because there were no schools or teachers for them. In such a situation the question of educating handicapped children is obviously an academic one. Similarly, regarding employment, if there are too few jobs for the able-bodied there is little hope of widespread support for a more intensive program of vocational training for the handicapped.

Marshaling public support for a program of education for the handicapped child also assumes the development of a sense of social responsibility for the less fortunate citizens of a community. It is possible for this concept to develop even in an impoverished country like Greece, where the ancient tradition of medical care of the indigent has been recently revived. Generally, however, the poorer countries of southern Europe have not yet developed a widespread community acceptance of social responsibility for meeting the needs of the less fortunate, whether able-bodied or handicapped.

In apportioning funds for services among disability groups, allocations should be made according to real need rather than according to traditional policies that usually favor certain categories. This happens in some instances where the blind and deaf, for whom special provisions were made earliest in every country studied, retain a preferential quota of financial support, even though as much or even more is needed by other groups for whom concern developed somewhat later.

Preparation of Teachers

In Europe there needs to be more widespread adoption of the concept of the team approach in meeting the needs of the handicapped child. In the northern countries this concept is embodied in educational programs to a greater extent than in the southern countries. In some instances the medical or welfare approach still dominates the picture, with education given secondary emphasis. Special educators in Portugal, for example, point out that the services provided in that country for the handicapped child are still predominantly medical in nature, with medical personnel in charge of some of the special schools and determining their educational activities. In some cases there is a division of concern on the part of the medical profession, as in Switzerland, where medical interest has centered around orthopedically handicapped children, leaving the responsibility for children with sensory handicaps to special educators.

More rapid development of adequate team services for the handicapped children is not possible in many nations because of the lack of trained personnel. This is an acute problem in most Western European countries. There are, of course, some notable exceptions in certain nations with

respect to certain component professions of rehabilitation. In northern Europe physical therapy is the notable exception. In comparison to the current national average of one physical therapist for each 22,000 persons in the United States, the ratio is 1:12,000 in France; 1:6,000 in Great Britain; and 1:2,600 in Sweden. In contrast, the first school for physical therapy has just been started in Ireland and there still are no such schools in Spain and Portugal.

Most countries in Europe lack sufficient numbers of all types of professional workers in rehabilitation and lack training programs for such personnel. The need for adequately trained special teachers is particularly acute. At present some countries, such as Austria, England, France, Germany, and Poland, require all their special teachers to have had specialized training, but others require specialized training only for teachers of the blind and deaf. In a few countries, such as Greece and Spain, no specialized preparation is required beyond certification for teaching nonhandicapped children. In general, teachers of the deaf are the groups most often expected to have had special training, with teachers of the blind ranking next. In Italy still a different kind of problem arises in providing enough trained special teachers. The government grants salary increases to teachers receiving special training but does not specify that they use this specialized training with handicapped children. As a result many teachers qualified for special education use their training as a means for improving their salary status but continue to teach normal children.

Most countries need more exact definitions of the nature of professional training and standards of competence in special education. It would be desirable to acquire some preliminary experience in teaching the normal child, though most countries in Europe do not expect or require this. Training is most frequently inservice in type and ranges from one to five years in length, although in Poland a four-year correspondence course may be substituted. These teacher-training efforts currently need more frequent supplementation with formal academic experiences as a transition to eventually providing full-time academic programs. It would also be desirable to have some central agency such as the national government determine the basis for, and actually issue, the certificates or licenses for special teachers. At present in most countries the special diploma or certificate is issued by the training school or institute itself.

In addition to increased professional status, special teachers need further incentives to enter the field and to keep improving their instructional technics. In only about half the countries surveyed are the salaries of special teachers higher than those of regular teachers. In Greece and Italy the special teacher sometimes actually gets less. Opportunities for promotion for special educators in

regular administrative jobs are limited. Incentive for the improvement of instruction should come in part from special education publications. Professional special education journals are issued in 15 of the 21 nations studied, but in only 7 are there journals for which special education personnel themselves are responsible.

Vocational Training

In the United States most of the prevocational training for handicapped children is given within the school itself; in Europe this training has traditionally been given through the apprenticeship system. This has worked a particular hardship on handicapped youngsters as a group because individual employers are often unwilling to accept severely disabled youngsters as apprentices. Such a system, based on the craft tradition, is directed toward a full competence and wide variety of skills in all components of a given craft. For example, the master craftsman in cabinetmaking must have the physical abilities to perform the wide variety of tasks involved in the complete process of the transformation of raw material into the finished product. In a mechanized economy the process is broken down into component operations, and the worker, rather than performing the complete range of operations, specializes in one individual operation requiring a more limited range of physical capacities, such as the operation of a lathe turning the spindles of a chair.

As in the United States, there is a trend away from the traditional occupations of basketmaking, brushmaking, and chair caning for the blind and deaf, but this trend has been much more gradual in Europe. Only limited attempts are made to train the blind and deaf for business and industrial activities, with specially adapted machines and other equipment. The range of such office and factory opportunities obviously depends directly on the degree of industrialization of a particular economy, and so it is not surprising that countries like England and Germany offer more training of this kind than do Greece and Yugoslavia. Only within recent years has the manufacture of brushes moved from the home into the factory. One of the significant achievements of which Greek leaders in rehabilitation are extremely proud is the establishment of a policy of preference for government purchases of brushes from sheltered workshops employing handicapped persons. In the United States such a policy of preferential government purchases of articles made by the blind was established by the Wagner-O'Day Act in 1938.

Although there are growing tendencies, as in England, to separate specific vocational training from the basic general educational programs in elementary and secondary schools, there are still many institutions in Europe that attempt little beyond training in rudimentary academic and vocational skills. Illustrative of these are schools in southern Europe where boys with shaved heads, dressed

in identical smocks, are receiving training rather than education from teachers who conceive their responsibilities to be limited to the imparting of skills and information.

In general, leaders in special education in Europe recognize the need for more adequate vocational guidance, placement, and follow-up work for the handicapped. They realize that there must be more varied offerings to take into account the individual differences of handicapped pupils and there must be programs of testing and counseling, in collaboration with teachers and parents, to help the young person find the type of work for which he is best fitted in terms of his handicap, his personality, and other special characteristics. These leaders also stress that in each nation there should be a well-organized, centralized system of providing employment assistance for the handicapped. In the past many individual institutions and agencies in various nations have undertaken this task, but such efforts have met with success only in nations such as England where this responsibility is vested in the government, which operates a network of local placement officers specially trained for this work.

The World Veterans Federation at its Eighth General Assembly in Rome in April, 1959, voted to sponsor the development in many of the European nations of programs similar to that of The President's Committee on Employment of the Physically Handicapped in the United States. Preliminary meetings to establish such committees are planned in Italy, Germany, the Netherlands, and France during the current year.

Also needed in most European nations is closer cooperation between educational and employment authorities to help the handicapped young adult after he has finished his educational program to meet his employment, housing, medical, and related requirements. European special education leaders point out the need for follow-up services in many nations to help the handicapped young adult adjust emotionally to his new role, find friends and satisfying social activities, or even change his job when that seems desirable. Other needs reported by special education authorities relate to the homebound person; there should be a systematic effort to obtain orders for him, supply him with the needed equipment and materials, collect his finished products, and distribute them to the appropriate markets.

Institutionalization

Present residential institutions in most European countries need to be relocated closer to the homes of the children served. Too frequently the criteria for such institutions in the past have consisted of "a large building on the side of a hill with a beautiful view and plenty of fresh air." There are still too many huge, cheerless, barracks-like institutions built in the nineteenth century housing several hundred children who are both geograph-

ically and emotionally removed from their families and friends. Some countries, like those in Scandinavia, have definite plans for decentralizing such institutions, but in no country has such a program been completed.

Such decentralization would facilitate the achievement of the goal of closer ties with the child's family; parents are increasingly recognized as an important unit in the complete program of services provided for the handicapped child. Where it has not yet been feasible to break down larger institutions into smaller units within week-end visiting distance of the children's families, more efforts are being made to personalize the institutional treatment and to simulate home conditions, as in the "cottage plan" arrangement in one Danish school. Here the children are divided into "family-size" groups of not more than 16 boys and girls of varying ages living in separate buildings with a married couple as substitute parents in charge of each group. In other cases children are placed in nearby foster homes instead of being housed in the school itself.

But in many countries the evidence of this concern for preserving family ties is the provision in a residential school for a few day pupils who live within commuting distance. More adequate provision by voluntary or public agencies of transportation facilities for handicapped children would make possible many more arrangements of this kind.

European special education authorities recognize that emphasis on family ties must be part of a broader objective of integrating the handicapped child into the life of the normal community. The development of day schools, they point out, should be accelerated to achieve this end. A few persons object to this concept because of administrative problems, which can be solved more easily through grouping homogeneously by disability categories. Their objections are being overcome by experiments that in some instances have already proved themselves, such as a day school for the blind and another for the deaf in Sweden. In Europe the great majority of special schools for all categories of disabilities, however, are still residential.

Whether day or residential schools are provided, the isolation of the handicapped child is in some cases minimized by sharing activities with normal children, as in Girl Guides and Boy Scouts programs, the invitation of normal children to special programs in the special schools, the sharing of "Play Days" for handicapped and normal children, and joint vacations in holiday camps. These camps are still segregated for the most part, but a few camp experiments have been attempted in which both handicapped and nonhandicapped youngsters are accepted.

Even more important to American observers is increased opportunity for the handicapped child to attend regular schools, either as a member of a regular class with a little supplementary help such as speech therapy or instruction in lip reading, or as a member of a special class where the child can still share some activities with

his normal peers, as in physical education or music or craft work. The United States has gone farther than any country in Europe in efforts of this kind.

Homebound and Hospitalized Children

More adequate provisions are needed for the instruction of the homebound child, now officially provided in only half the European countries. The other countries depend on volunteers, only part of whom are qualified teachers. These programs are best organized in the United Kingdom, Scandinavia, the Netherlands, Germany, Austria, and Switzerland. In England, some local educational authorities employ permanent full-time itinerant teachers, but the usual procedure is to employ on a part-time basis former teachers who have married or retired.

Instruction throughout Europe is at best given the homebound child for only about an hour a day five days a week; more frequently the child is visited just once or twice a week, if at all. A typical example is that of Greece, where a well-to-do family may employ a private tutor for their handicapped child or teach the child themselves; otherwise instruction may be given in a few cases by individual volunteers or by voluntary organizations such as the Girl Guides Association. A few correspondence courses are given, some of which instruct by radio. Norway, in common with other European countries where broadcasting has traditionally been a government monopoly, devotes a considerable portion of its programming to school broadcasts; this is especially advantageous for homebound children.

In every country except Spain some arrangements are made for the instruction of children who are hospitalized for long terms. These programs are well developed in the northern countries and in Poland, where "educational aides" supplement the work of the regular teachers. These aides, who must be trained, certified teachers, have charge of the children through all their waking hours except those spent in the classroom; they help the children write letters, play games, and prepare assignments. Thus they do the work that is done in many other countries by social workers and volunteers.

In some hospitals, as in Ireland, children are taken from their wards to special classrooms, even though it may mean moving them in their beds, while in other hospitals a teacher stations herself halfway down a row of 16 or 20 beds, while lecturing to the pupils. This kind of arrangement can result from crowded hospital conditions, a shortage of trained teachers, or the idea that classes are held only to comply with "unrealistic" laws.

International Cooperation

The advantages of international cooperation in facing the problems of educating and caring for handicapped children need to be more generally recognized in Europe

and implemented through the strengthening of such voluntary groups as the World Commission on Cerebral Palsy, the Committee on the Education of Crippled Persons, and the World Commission on Arthritis and Rheumatism of the International Society for the Welfare of Cripples and such professional groups as the World Confederation of Organizations of the Teaching Profession. Also needed are increased availability and use of the consultative services of international experts.

Mr. James Lumsden, Her Majesty's Chief Inspector of Special Schools in England and Wales, pointed out at the annual meeting of the Council for Exceptional Children in Atlantic City in April, 1959, that there is no international organization of teachers for the deaf to promote the international exchange of technical information. Although an international congress devoted to this subject was held in Manchester, England, in August, 1958, it developed spontaneously as a follow-up of a similar conference held earlier in the Netherlands. Although some special teachers attend international meetings in other European countries, additional governmental subsidies for such purposes are needed to extend these activities and to further international exchange of concepts and practices in special education.

The greatest single action that could be taken to strengthen international cooperation to advance special education services for handicapped children would be the development of a program of leadership, consultative services, and technical assistance within the United Nations Educational, Scientific, and Cultural Organization (UNESCO). During the past 10 years there has been a great emphasis on the social, vocational, and medical aspects of rehabilitation services for the physically handicapped through the United Nations, the International Labour Organization, and the World Health Organization. Each of these organizations has specialists in these areas and operates technical assistance programs including consultant services, fellowships, and provision of equipment and supplies. In contrast, UNESCO has had no staff specialist in special education of handicapped children since 1950. Nor has it conducted any significant technical assistance activities in special education. Its last major activity was a Conference of Experts in Geneva in March, 1950, cosponsored with the International Union for Child Welfare.

The Council of Exceptional Children, at its 1959 conference at Atlantic City in April, voted to petition the United States National Commission of UNESCO to take leadership in the development of a program of special education within UNESCO. As a first step, they went on record as favoring the appointment of an expert to the Secretariat of UNESCO and the appointment of an expert advisory committee on special education to the Director General of UNESCO.

Conclusions

European countries in general still tend to think in terms of "a handicapped child" in contrast to our own emphasis on "a child who has a handicap." The problems of special education in Europe, however, are basically the same as the problems of the special education of handicapped children in the United States and Canada. The solutions are also parallel. The most striking difference is the slower progress made in Europe toward the achievement of these solutions. This slower progress is caused by a variety of factors: (1) the complexities of large numbers of political subdivisions, languages, and cultures; (2) a less uniform degree of industrial development; (3) the interruption of normal progress resulting from depression, World War II, and reconstruction; and (4) the added burden of increased case loads and damage to facilities and programs during World War II.

In each European country, however, growing public support strengthens the efforts of those dedicated leaders determined to give every child the opportunity to become what he is capable of becoming.

References

This article is based on material gathered largely from unpublished government reports and the reports of voluntary societies supplemented by data provided specifically for this study by means of questionnaires and interviews with leaders in special education in each country. Most of the articles used have appeared in periodicals published in the language of the country and are not available in English.

A detailed bibliography of references for the present study will be available when the finished report on which this article is based is published in book form by the International Society for the Welfare of Cripples in late 1959. In addition, abstracts of significant published materials in English on the education of physically handicapped children in various European countries have appeared regularly in *Rehabilitation Literature*.

The October Issue

In the October issue of *Rehabilitation Literature*, the Article of the Month will be "Work and the Social Life of the Handicapped," by E. Louise Ware, Ph.D. In the Review of the Month, Robert J. Wolff, Ph.D., will discuss the new book *An Experiment in Mental Patient Rehabilitation*, by Henry J. Meyer and Edgar F. Borgatta (New York, Russell Sage Foundation, 1959).

Review of the Month

The Psychology of Exceptional Children

By Karl C. Garrison, Ph.D.

and

Dewey G. Force, Jr., Ph.D.

Published by Ronald Press Co., 15 E. 26th St., New York
10, N.Y. 1959. 586 p. figs., tabs. (3d ed.) \$6.00.

Reviewed by Francis E. Lord, Ph.D.

About the Authors . . .

Dr. Garrison has been Professor of Education at the University of Georgia since 1948. He is author of several educational texts; the first edition of the book under review here was published in 1940. He received his Ph.D. in 1927 from George Peabody College for Teachers. Dr. Force joined the faculty at the University of Georgia in 1954 as Assistant Professor in Special Education after receiving his doctoral degree from the University of Michigan. He was instructor in special education at Michigan State Normal College (now Eastern Michigan College) in 1952-1954.

About the Reviewer . . .

Dr. Lord since 1953 has been Head of the Department of Special Education, Los Angeles College of Applied Arts and Sciences. From 1926 to 1953 he was on the faculty of Michigan State Normal College where he was Professor of Education and Director of Special Education from 1941 to 1953. Dr. Lord served as Editor of *Exceptional Children* for 10 years, 1943-1953. He received his doctoral degree from the University of Michigan in 1936.

This third edition represents a complete revision of *Psychology of Exceptional Children*. The contents of this edition have been expanded some 69 pages over the second edition. The text is organized around five major divisions or parts as follows: Children: Human Resources; Mental Deviates; Physical Disability; Neurological Impairments and Health Problems; and Emotional and Social Maladjustments. In appearance this book is another sober textbook. The photographs are limited to two uninteresting half tones. The content is primarily general and descriptive rather than illustrative. Little has been done to enliven the book and make it appealing to a beginning student. These limitations do *not* necessarily set it apart from many textbooks in education.

Survey textbooks in any comprehensive field present many difficulties for an author. First, space is too limited in a single volume for an adequate treatment of the subject. Second, the survey approach is likely to represent either of two extremes—oversimplification of the topics or a rather highly generalized presentation. Finally, it is very difficult for one or two authors to bring expertness to a wide variety of phases of a subject. The textbook under review covers the full range of subject matter commonly classified as special education. Attention is given to the gifted, severely retarded, and brain-damaged, as well as the major categories of handicapping. A helpful glossary is included. The simple organizational structure of the text and the inclusiveness of the treatment are two of its better features. One may quickly differ with the apportionment of the space, but the coverage seems complete.

In the discussion of "special curricula" for retarded children a page of space is used. A live discussion of this topic should give a reader who is getting his first acquaintance with the field some concepts of the educational process, special curricular adjustments, and the adjustment

of goals as reflected in the curriculum. The brief discussion of this vital topic gives little insight into the dynamics of a special curriculum for retarded children. The following sentences reproduced from the text are generalized statements and require some explanations or illustrations to make them meaningful; after briefly discussing the unit plan of teaching, the authors conclude as follows:

The curriculum for the educable mentally retarded should be plotted on a broad horizontal level rather than along the steeper vertical ascendancy which typifies the curriculum for the normal child. This implies that the mentally retarded child will not be able to handle concepts as broad or complex, or to reach such heights in abstract thinking, problem solving, and creative activities, as would ordinarily be the case for the average or above-average child.

Such generalized statements found all too often in education textbooks add little to the insight of the reader, especially the reader who has limited professional background. These statements are "author centered" rather than "learner centered."

The topics that follow the discussion of special curricula are special classes, integration, and residential schools. These related topics consume more than eight pages. When one contrasts this space allowance with the page devoted to curriculum, it appears generous. It would seem that the beginning student would profit from a greater insight into the instructional needs of these children rather than a lengthy discussion of administrative organization of classes. One gets the impression that the "writer's eye" is focused more upon his professional background than the satisfaction of the young reader's desire to know what this field of work is all about.

Common faults of survey textbooks are brevity in presentation and descriptions characterized by generalizations rather than information that leads to generalizations. It is the reviewer's opinion that fewer topics and fewer concepts might well be treated and that these presentations should be enriched, illustrated, and enlivened. Certainly the topic of special curricula lends itself to illustrated descriptions that are a fair substitute for a brief room visitation.

The content of the book seems to be authoritative and well documented. Newer sources of information are utilized. Considerable tabular data are presented throughout the text to illustrate the descriptive content. Three lengthy chapters totaling approximately 100 pages are devoted to emotional problems, antisocial behavior, and personality disturbances. While this discussion may overlap the student's courses in mental hygiene and educational psychology, it does seem appropriate here since problems of adjustment are so common among exceptional children.

There is no particular underlying philosophy portrayed throughout the text. The introductory chapter "Children—Their Assets and Liabilities," which is very appropriate, does not set forth guiding principles for the structuring of the later chapters. Again, the failure to set forth a rationale for the services for exceptional children does not set this book apart from similar textbooks. Perhaps the introductory chapter of the present volume, which has such a well-chosen title, invites the reader to look for some foundation of the field being discussed.

The writer commends the authors for the extensiveness of the revision job. The text will be well received since it is complete in its treatment, compact, and informative. It is a very usable textbook and ranks well among the other single-volume books in the field.

Other Books Reviewed

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Anesthesia for Infants and Children

By: Robert M. Smith, M.D.; Foreword by Robert E. Gross, M.D.

1959. 418 p. illus., figs., tabs. C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, Mo. \$12.00.

A DETAILED and comprehensive summary of anesthetic methods found most practical and useful in pediatric surgery, written by the head of the anesthesiology service at Children's Medical Center, Boston. In addition to chapters discussing technics and equipment for administering anesthetics in specific types of cases, Dr. Smith has included explanations of the basic requirements in pediatric anesthesia, factors determining the child's response to anesthesia, preparing the child for operation, mortality in

pediatric surgery and anesthesia, and the legal aspects of pediatric anesthesia. References following each chapter have been chosen in regard to general availability. Chapter 3, on respiratory physiology in infants and children, was contributed by Charles D. Cook, M.D.

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Directory of Agencies Serving the Blind in the United States and Canada

Compiled by: Hilma Saterlee

1959. 222 p. (11th ed.) American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y. \$3.00.

THIS IS A REVISED edition of a directory of agencies, both governmental and voluntary, that provide services for

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the blind, the first published since 1954. In an attempt to reflect established patterns and developing trends in services, a new format has been adopted that makes for more convenient reference. Sections cover federal agencies, national voluntary agencies, and statewide, local, and regional services. Also included is a supplementary list of voluntary organizations with regional, nationwide, or overseas services. Generally, the agencies listed are those established nonprofit organizations that provide services for blind persons either as a sole function or as an appreciable segment of their programs, that maintain established service headquarters, and that have paid staffs. Information given on state-by-state services describes the federal-state program of aid to the blind, educational services (student census, residential and local community schools), library services, vocational rehabilitation and other special services, and local and regional services under voluntary auspices. Contains an index.

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Education for Social Workers in the Rehabilitation of the Handicapped: Vol. VIII, A Project Report of the Curriculum Study (Werner W. Boehm, Director and Coordinator)

By: John J. Horwitz

1959. 76 p. Council on Social Work Education, 345 E. 46th St., New York 17, N.Y. \$2.50.

A COMPREHENSIVE three-year study of the total curriculum in the education of social workers has been undertaken by the Council on Social Work Education. Twelve individual project reports comprise the total study; each was planned to identify educational objectives in existing curricula and to suggest desirable objectives to be incorporated in revised courses of study. Major areas covered by the study were: specific curriculum considerations; selected fields of practice (of which this is one); undergraduate education for social work; and social work values and ethics throughout the curriculum. This particular report defines the role of social workers in rehabilitation, their functions in the provision of direct and indirect services, and the basic methods of social casework practice as applied in the rehabilitation setting. The author stresses the need for interpretation of the team concept, more adequate communication between professions, and the ability of the social worker to adapt to varying patterns of leadership. Social work theory within the framework of rehabilitation programs is discussed as it relates to actual practice.

The 13 volumes of the series may be purchased as a set for \$37.00; individual volumes may also be purchased.

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Nursing Home Management

By: Ralph C. Williams, Margaret Bull Armstrong, J.

Fred Gunter, Edith McCulloch, and Jack Stiller

1959. 230 p. illus., tabs. F. W. Dodge Corp., 119 W. 40th St., New York 18, N.Y. \$8.50.

IN 1958 THERE WERE an estimated 25,000 to 30,000 nursing homes in the United States, mostly privately operated. Administrators of such homes more frequently than not have had no particular training in this work. This book, comprehensive in scope and most timely, should serve as a basic reference source on all phases of organization, operation, and management of the nursing home or home for the aged. Specific chapters discuss establishment and organization, business management, medical and nursing care, recreational facilities and group programs, food service, housekeeping and laundry departments, maintenance of buildings and grounds, and aspects of a safety program. Especially useful is the information on licensing and regulatory laws, maintenance schedules, personnel policy statements, and sample by-laws and code of ethics. The chapter on food service gives both regular and modified diets, suggested menus, and information on record keeping and equipment. Illustrations are abundant and should prove useful in teaching aspects of nursing care.

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Parade to Glory: The Story of the Shriners and Their Hospitals for Crippled Children

By: Fred Van Deventer

1959. 304 p. illus. William Morrow and Co., 425 Fourth Ave., New York 16, N.Y. \$6.00.

WRITTEN BY THE Imperial Historian of the organization, this account of the founding of the Shrine in 1870 to the present day is a narrative history of a fraternal order famous as the "apostles of good cheer" and the "fun organization of Masonry." Through its pages romp the leading personalities and the rank and file of the "nobility," who even created a mystic legend to stimulate interest in membership. The scope of Shrine activities took a more serious turn in 1919 with the advent of Freeland Kendrick as Imperial Potentate; until that time charitable acts of local Shrine temples were more often accomplished with nearly complete secrecy. Kendrick's interest in the Philadelphia Home for Incurables, plus Forrest Adair's interest in the Scottish Rite Hospital in Atlanta, led to the passing of a resolution in 1920 authorizing support for Shriners hospitals in both the United States and Canada. Currently costing some 7 million dollars a year, the program has expanded to 17 such hospitals accepting needy children regardless of race or creed. Included among the units are two in Canada, one in Hawaii, and one in Mexico. The hospitals are supported by such special events as the Shrine circuses and regional football games and by the annual \$5.00 assessment of the more than 800,000 members.

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Pediatric Neurology

By: Stanley S. Lamm

1959. xii, 495 p. illus. Landsberger Medical Books, Inc., 51 E. 42nd St., New York 17, N.Y. \$12.90.

THIS SMALL TEXTBOOK of neurology of infancy and childhood will be one of interest not only to pediatricians who occasionally see neurological disorders in this age period, but also to physical therapy technicians who have to do with trying to neutralize the effects of some of these diseases by physical measures. It will be the source of much help to secure a quick, concise, and accurate view of the background of a number of these diseases. Particularly helpful will be Chapter VI, concerned with cerebral palsy, which contains a generous portion of pages on the management of such problems, including habilitation, physical therapy, and occupational therapy, as well as the surgical aspects of such conditions. Of course, in a small text one could scarcely expect to find the technics of physical therapy, but if the physical therapist is alert and wishes to discover the background of the reason special measures are applied, this book will serve a most useful purpose. In the reviewer's opinion, every physical and occupational therapist should have such a book on his "active" reading shelf. The best argument for this conclusion is the recognition that the great majority of locomotor disorders in early life are neurological in origin.—Reviewed by Cyril B. Courville, M.D., *The Institute of Nervous Diseases, Los Angeles.*

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Physiology of Motion, Demonstrated by Means of Electrical Stimulation and Clinical Observation and Applied to the Study of Paralysis and Deformities

By: G. B. Duchenne; translated and edited by Emanuel B. Kaplan

1959. 612 p. figs. W. B. Saunders Co., W. Washington Sq., Philadelphia 5, Pa. \$11.00.

DUCHENNE, born in the early years of the 19th century, became interested in the application of faradic current in the treatment of various diseases and soon realized the possibilities of this method in diagnosis and treatment. In 1867 his most important book, of which this is the first English translation, was published. The translator believes

Duchenne's book should be of great value to the functional anatomist, neurologist, orthopedic surgeon, and kinesiologist working in the field of rehabilitation since it contains an excellent record of the kinesiography of the entire muscular system. Duchenne, considered one of the greatest clinicians in the history of French neurology, was credited with the discovery of locomotor ataxia, progressive muscular paralysis, and glossopharyngeal paralysis, as well as locating the lesion of poliomyelitis in the anterior horn of the spinal column. This book consists of four parts covering the study of motion of the thoracic and abdominal extremities, the motion of respiration and the vertebrocranial column, and a description of Duchenne's experimental studies on the function of muscles of the face.

This edition is apparently a reissue of the same volume published by J. B. Lippincott in 1949.

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Recreation in Total Rehabilitation

By: Josephine L. Rathbone and Carol Lucas

1959. 398 p. Charles C Thomas, Publisher, 301 E. Lawrence Ave., Springfield, Ill. \$9.50.

BOTH THE theoretical and practical aspects of recreation in rehabilitation programs are emphasized in this book prepared especially for administrators of institutions, rehabilitation team personnel, students of recreational therapy, specialists in the recreation field, nurses, social workers, occupational therapists, and members of patients' families. Part I discusses the basic philosophy and current trends in recreation in rehabilitation programs, as well as problems of patients being served in special facilities and in their homes. Part II provides orientation to the medical implications of specific conditions and diseases and their influence on choice of recreational activity. Part III, comprising the major portion of the book, should be most useful in program planning. Suggestions on the use of such media as music, graphic and plastic arts, hobbies, crafts, nature study, literature, dramatics, games and sports, dancing, and special events in recreational planning for the homebound and institutionalized patient are presented. A nine-page bibliography and an index add to the usefulness of the book. The authors, both leaders in recreation for the ill and handicapped for many years, have helped to clarify the role of recreational specialists working in the rehabilitation field.

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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The Functional Assessment Unit

By: Phyllis M. Howie, M.A.O.T. (*King's College Hospital, Denmark Hill, London, S.E. 5, England*)

In: *Occupational Therapy*. June, 1959. 22:6:23-27.

To the lady over 70 years of age, who has fallen and fractured her femur and withstood the shock of an operation, the shining expanse of ward floor appears formidable. Settling herself in her chair, she resigns herself to dying in Hospital, yet dreams of home. Such patients might block for months beds badly needed in acute cases. Ready to walk within 10 days following the accident, they remain in Hospital because rehabilitation programmes have not kept pace with the rate of recovery made possible by modern surgery. Constructive planning was obviously needed for these elderly folk in the general Hospital who had been receiving routine Physiotherapy and training in daily living activities by the Occupational Therapist. A programme conducted in therapy departments separated by some distance would be too taxing on their limited strength; accordingly, a new training unit was set up at one end of our Physiotherapy Department. Since their homes were often cramped and awkward, the patients needed training under conditions approximating those to which they would return. Ideas of shining modern equipment were abandoned; an old bath, divan, ordinary chairs, and lavatory came up from the basement for the Unit, which also included steep stairs and the beginning of a kitchen. Since the nucleus of training was common to the teaching areas of the Physiotherapist and the Occupational Therapist, both were assigned to the Unit and aided by one student from each profession. And so the Functional Assessment Unit went into action!

Patients now present a fairly regular pattern; most numerous are elderly ladies, averaging 76 years of age, with fractured femurs. Those with hip disabilities, mainly osteoarthritis requiring arthrodesis or arthroplasty, are frequent attenders, and each week there are several hemiplegics and amputees and a few neurological patients. Individual assessment and short-term treatment and training are given at sessions lasting either a half-hour or hour, with the number of visits required varying according to disability, age and physical status of the patient, and her home conditions. The 75-year-old lady with a fractured femur would average 8 visits; hemiplegics usually attend 15 sessions.

It is a help in the subsequent training of the patient to see how and where she lives. A "Home Visit" to assess the situation is made by either therapist with one or both students. One does not realize until it is seen that the only running water is a cold tap on the twist of a steep spiral stair and the bed is too high and topped by an all-embracing feather mattress. The cooking facilities might be one gas ring on a wooden floor, which the stiff-hipped old lady lights by kicking at the tap with a foot and throwing matches at the ring. However sordid or drab or drear a room appears to the visiting therapist, it is still "Home" to the patient. Accurate measurements of the heights of steps, chairs, lavatory, and beds are taken. We are grateful to the Technician of the Occupational Therapy Department who with speed and good humour responds to many, often strange, requests and fits up the home with the needed ramp, bath seat, rail, or trolley.

Patients are brought by wheelchair for their first visit to the Unit, arriving frightened and apprehensive about trying to walk. The mention of home brings a gleam of hope into the faded eye. On their second visit they don their own clothes and change suddenly from invalids preparing for a final stay in Hospital to persons determined to get on and get home. Progress from then is remarkable. The elderly lady with the fractured femur comes to the Unit 2 weeks after the accident, attends 6 to 10 sessions, and is home within a month of her fall. Activities of the training programme vary according to need. Patients practice changing positions in bed, unaided where possible; next are chair activities—learning to sit and stand safely and how to manage walking aids when doing so. Ideal chair height is determined for each patient.

Ambulation training and the use of walking aids or the wheelchair are taught according to type of disability; safety is the paramount consideration. Blocks of varying height are helpful in concocting door steps and kerbs. Use of bathroom facilities is practiced; special devices are provided to overcome problems posed by the individual's disability and home conditions. The best plans can miscarry sometimes, as when one lady confessed in a whisper that the commode given her "was much too beautiful to use" and she continued to climb dilapidated stone steps without a railing to go down a broken path to the bottom of the garden. Dressing instructions are especially needed by hemiplegics and those with hip disabilities. Alternative methods are often a solution; simple basic self aids are

provided only where absolutely necessary. For patients using two walking aids, carrying becomes a difficulty; sling bags or trolleys may be of use. Practice in carrying, bending and picking up objects, reaching, standing to wash, and general mobility is included in training. Patients needing further training in the kitchen are referred later to the unit set up in the Occupational Therapy Department.

Short-term training often allows only time to teach basic activities; ability to move safely and independence in daily living activities are thus the main goal. Mutual training of patients and relatives with whom they plan to make their home has proved most beneficial to both. Advice and help to aid in home adjustment are available at any time from the Unit. One patient decided that, if her final training had included two excited dogs, two cats, and two children, it would have been of help when she went home!

Working relations between the Unit and other departments and personnel of the Hospital are close; on the Ward rounds the patient may be referred by the Sister, Physiotherapist, or Almoner, with the consent of the Doctor. Close liaison with the Physiotherapist on the wards and in the Gymnasium prevents duplication of services. Social service needs of patients are the responsibility of the Almoner; other services outside the Hospital are utilized, especially after the patient returns home. The patient's own doctor is notified at the time of the patient's discharge so that he may keep an attentive eye on her. "Meals on Wheels" may provide the hot dinner and "Home Helps" will visit and do the shopping and cleaning; the L.C.C. Welfare may put in banisters and raise lavatories and chairs; and the patient may be visited by the Health Visitor and District Nurse.

The Unit functions also as an invaluable aid to inservice training of professional personnel and students, promoting a broader outlook on the potentials of rehabilitation services and closer contact between Physiotherapist and Occupational Therapist. Home Visiting and personal care activities are new to Physiotherapists and widening to their horizon.

Comments from patients discharged from the Unit are revealing and enthusiastic; their progress has been a source of great satisfaction to the staff, especially as they recall frail elderly patients formerly resigned to spending the remainder of their days in a Hospital bed. As one 85-year-old from the north, who went home one month after her fall, able to walk with one stick and to dress with one hand, said—"All ye need is a wee bittie deterrrrmination, and ah'm verra deterrrrrmined."

Occupational Therapy is published by the Association of Occupational Therapists, 251 Brompton Rd., London, S.W. 3, England; 3s a copy.

Tempered Optimism in Rehabilitation of the Severely Disabled Patient

By: Charles Long, M.D. (*Highland View Hospital, 3901 Ireland Dr., Cleveland, Ohio*)

In: *Ohio State Med. J.* Feb., 1959. 55:2:194-196.

A major factor in the outcome of rehabilitation of the chronically ill or severely disabled patient is the attitude of the physician and his team of associates. Optimism transmitted to the patient is a useful tool. Both physician and patient tend to err in the direction of pessimism. Such disabilities as stroke and amputation are more amenable to rehabilitation than is generally understood. Age in itself is no indication for pessimism. The communication of optimism firmly tempered by reality in the form of intelligent goal-setting will do much to further rehabilitation. The physician with a firm enough knowledge of the patient's physical capabilities to avoid error and to estimate the potential goals can give relatively optimistic support.

Hemiplegia. The future of the patient with hemiplegia is certainly brighter than the general medical impression and many myths surrounding treatment would indicate. In motor aphasia the aphasia presents no deterrent to self-care and ambulation training; the patient will satisfactorily adjust in the absence of expression. In receptive aphasia the depth of verbal auditory agnosia or diffuse brain damage interfering with learning or understanding will limit rehabilitation. The degree of brain damage consistent with ambulation training is remarkable. Almost all hemiplegics conscious after the first attack can be taught to walk, although the more severely involved may need continued supervision. Continued incontinence of bowel or bladder should be rare. Use of a catheter is often unnecessary if a bedpan is regularly presented or trips to the bathroom made routinely.

Many physicians fear an occurrence of coronary, hypertensive, or cerebrovascular incidents during therapy. In several hundred sessions using the whole gamut of therapies and with the majority of patients severely disabled, I have seen only one instance of fatal pulmonary embolism, one very minor coronary occlusion unproved by electrocardiogram, and no cerebrovascular accidents.

The emotional lability seen after a cerebrovascular accident is often brief and is more often a reactive depression than a true pseudobulbar effect, which can best be detected by its inappropriateness and failure to respond. It can be expected when there are bilateral neurologic changes.

In hemiplegia a prognosis based on the paralysis present is extremely unreliable in determining if the patient will be independent in walking or self-care. A patient with completely flaccid limbs unilaterally has an excellent chance of full rehabilitation. Another with partial control

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of arm and leg and with severe underlying spasticity or ataxia might be severely disabled.

Aphasia, incontinence, paralysis, or emotional lability in combination need not be disastrous, for each problem is treated individually.

Amputation. Many practitioners are discouraged by amputation. Almost always the below-knee amputee can be rehabilitated to complete ambulation without a cane. An above-knee amputee is a good candidate for complete ambulation but may need a cane. Bilateral amputation gives the most trouble, although Arthur Watkins recently reported a large series of such patients with 70 percent success in rehabilitation to the ambulatory level.

Optimism, of course, can be overdone. Realistic appraisal of the patient's physical potential can reveal unpleasant facts. (Such restraint to be exercised is illustrated by a chart showing the predicted physical potential of paraplegic or quadriplegic patients with spinal cord injury at several critical levels.)

Goals. Through objective evaluation of the patient's physical capacities, the physician can balance his own hopes and fears for the patient, or his own optimism and pessimism, and arrive at a firmly realistic plan. This reality-based plan must be transmitted to the patient with minimal psychic trauma and a maximum of hope, or optimism. Goals are set for and with the patient. The physician must keep in mind several goals so he may give maximal continuous support consistent with the disability and reality. A *probable final goal* is the grossly realistic final goal to which the patient can aspire. If optimistic, it can be a great source of hope for the patient. An immediate boost is often given by the words "We can certainly teach you to walk!"

Obviously, facing the patient early in his rehabilitation with a grossly depressing goal is not helpful, no matter how realistic. Here a *limited goal* can divert the patient's attention from the final goal and is a logical step in reaching or accepting the real goal. It may be suggested to the severely quadriplegic that he concentrate on self-feeding activities as a first step before the next is discussed. This gives the patient time to assimilate the severe trauma that has befallen him and lets him perform at a level at which he is truly capable. The patient sometimes works out for himself his final, probable goal.

Another type of goal can be called the *extraordinary goal*. The physician has high hopes, but he does not dare tell his patient for fear of causing frustration if the hopes fail to materialize. The goal is kept in reserve, as a new path to follow if things go well or as an exhortation to greater effort if the patient's ambition flags.

The goals must pervade every activity the patient performs. He and the entire team treating him should think in the same direction. The patient should be shielded from behind-the-scenes disagreements of reevaluation confer-

ences and combined rounds. The atmosphere should be positively charged, with the patient feeling that everyone treating him knows his case well and agrees on treatment.

The Ohio State Medical Journal is published monthly by the Ohio State Medical Association, 79 E. State St., Columbus, Ohio; subscription rate, \$5.00 a year.

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The Physically Handicapped Housewife

By: Central Committee for the Welfare of Cripples in Sweden (SVCK)

1959. 68 p. illus. (SVCK's publ. ser. no. 6) Published by SVCK and distributed in the United States by the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y. \$1.00.

In this booklet we have tried to illustrate the problems facing a physically handicapped housewife in doing her work. The booklet contains advice and instruction in home planning and equipment and the use of suitable aids. Many of the viewpoints and instructions are based on the experience and insight gained from a questionnaire sent in 1957 by the household group of SVCK to 625 disabled housewives. The results of this survey had great significance for SVCK activities. The directions concerning aids and special working technics listed in the booklet are to be regarded as only examples, for other devices and technics may be as good or better. We are in the early stages of development in this sphere and wish to compare notes with others.

Only a limited number of families in which the housewife is disabled are financially able to employ domestic help, and, of course, other personal problems are not answered by such a solution. A housewife prefers to attempt to carry out her duties despite the sometimes unsuitable design of her home and its equipment.

As the financial problem is especially urgent in Sweden, state subsidies for the equipping of homes for the disabled have been proposed. Government financial assistance to help the housewives buy special utensils is being considered. It is particularly desirable that this investigation of government aid should arrive at a satisfactory result without delay. Working aids for the disabled are often very expensive; they cannot be mass-produced. Household machines on the market are often too expensive and government subsidized purchase would seem well justified.

Some of the organizations now actively giving support and assistance are: Riksföreningen mot Polio (RmP) (Association Against Polio); De Vanförs Riksförbund (DVR) (National Organization of Cripples); Riksförningen mot Reumatism (RmR) (Association Against Rheumatism); and the Folksam Insurance Company. Pioneer work has been done by the Rehabilitation Center of the

City of Stockholm in establishing a training apartment at the institute of rehabilitation in Bärnängen. Training kitchens are to be introduced in other parts of the country at rehabilitation clinics and training institutions.

Early activities of the SVCK include work analyses in test kitchens with the former HFI, now known as the National Institute for Consumer Information. The SVCK technical committee, instituted in 1948, is devoted to the welfare of disabled housewives. In 1954 a special group called the household group was formed within the technical committee to extend and intensify activities devoted to problems of disabled housewives. This group works closely with the National Institute for Consumer Information. Household utensils and other articles recommended by the Institute or available on the market and considered particularly suitable for the disabled are tested in practice at the homes of handicapped housewives and at various institutions. If they are found satisfactory, the SVCK distributes instructions for use among institutions and officials dealing with the welfare of cripples and among those who need them. If a utensil needs improvement, it is altered and experimentally tested at SVCK workshops in Stockholm. When results are satisfactory, instructions are published. Often entirely new solutions to problems must be found, as articles on the market are not suited, frequently requiring extensive study of foreign publications, correspondence with other institutions, and experimental work with experts cooperating. Often a problem must be solved for a particular housewife to manage her work.

Personal instruction is also given in the form of home visits, workshop instruction to visitors, lectures, and demonstration tours. The press and radio are used. An SVCK film features a one-armed housewife and gives advice on care of the home and children.

The object of the 1957 inquiry of the SVCK household group was to get a better idea of the conditions of the housewives' daily life and to obtain a better basis for further activities in the field. The questionnaires were answered both by housewives who had to do their work under the worst possible conditions and by others who had successfully adopted measures to facilitate tasks. Half (310) the group of 625 housewives answering had had infantile paralysis. Effects of rheumatic diseases were present in 146 (23%). There were about 30 cases each (about 5%) of exterior injury and of organic nerve diseases. Other causes of disability were also reported. Epidemics were sometimes reflected in the duration of disability; in

the infantile paralysis group, 72 housewives reported less than 5 years' disability and 56 a period of 40 to 49 years.

Those in the infantile paralysis group had the greatest need of braces and mechanical aids. Some kind of self-help device was used by 250 (80% of those with after-effects of infantile paralysis). Supporting braces and walking aids were used by 103, while 46 used walking aids only, 45 braces and wheel chairs, and 27 wheel chairs only. In the rheumatic disease group, 81 (55%) required some kind of mechanical aid, with 42 reporting the use of walking aids only and 16 wheel chairs only.

Cars and other motor vehicles were used by 123 (23% of the total of 625), 90 of these being in the infantile paralysis group. Of these, 47 used braces and walking aids and 16 used wheel chairs. Ten of the rheumatic disease group used motor vehicles.

The homes of 10 percent of the 625 answering had no water supply or drains. No toilets were reported by 178 and no central heating by 184 (about 30% in both cases). About 40 percent had no bathrooms. Of 554 housewives answering a question about whether their kitchens were suitably equipped, 245 said yes. In 108 cases alterations in kitchen equipment were made because of the handicap. Often changes were thought of by the housewife. Sometimes self-help devices for the daily activities of living and housework were constructed.

The ability to go out was found to be largely dependent on the location of the apartment in the house. Of 243 cane users answering, almost half lived on the first floor or higher up; only 9 of these had access to lifts. About half the 109 wheel chair users also lived on the first floor or higher; only 7 of these had access to lifts. For many, getting out at all is difficult. If the door is wide enough to accommodate a wheel chair, a balcony can solve the problem of getting fresh air for those who have no greater need. Some housewives, however, have greater demands. They may want to shop personally, as they feel ordering by telephone increases expenses.

The greatest problem reflected in over 90 percent of the answers concerned finances. The housewives say they cannot afford to buy urgently needed mechanical aids. Where housing conditions are bad, housewives stated that, even if they could find a better apartment, they could not afford the higher rent. Others living in their own defective cottages could not pay for improvements that would make their homes better suited to their disability. Financial support by the authorities is the foremost requirement, which of course still leaves scope both now and in the future for complementary assistance on the part of voluntary organizations.

Information for Authors

As an interdisciplinary journal, *Rehabilitation Literature* is published for professional personnel and students concerned with the rehabilitation of the handicapped. It is intended to help the medical practitioner, therapist, and other personnel working with handicapped children and adults to keep up to date not only in his own professional field but also in other related fields. *Rehabilitation Literature* is in no sense the house organ of the National Society for Crippled Children and Adults. Contributors of featured articles and book reviews are people outstanding in their own fields and give free expression to their own ideas and opinions.

Correspondence with the Editor

The Editor will welcome correspondence with professional persons as to manuscripts they may wish to submit for possible publication or as to subjects that they suggest as desirable for an "Article of the Month." The Editor will endeavor to give prompt attention and due care to unsolicited manuscripts but prefers to receive an initial inquiry from an author before a manuscript is sent or even before the article is actually written.

Kinds of Articles

The Editor is interested primarily in featuring as the "Article of the Month" a review article in which the author will summarize current knowledge and recent developments in a specific subject field. The present status of the subject may best be documented by a review of the literature as well as by presenting the author's own experience and personal observations. In the course of his review of the subject the author should be able not only to report but also to evaluate and criticize what is being done and what is known. We hope that the author will be informed of current and recent research activities and will be able to discuss their implications in rehabilitation efforts. It is well for the author to keep in mind that although his reading audience is professional it is primarily an interdisciplinary one.

Preparation of Manuscript

The space allotted to "Article of the Month" permits the use of one of 6,000 words, or approximately 17

typewritten pages, elite type, double spaced. The bibliography or list of references may be in addition to the pages of text. The author is asked to organize his article so that it will include section headings. The original and one carbon copy of the article, carefully typed and corrected, should be submitted to the Editor. The author should retain a copy. The Editor reserves the right to return for revision to the author a manuscript that does not meet the standards of a professional journal or the editorial requirements of *Rehabilitation Literature*. The Editor may be permitted to make minor editorial changes if they do not materially change the author's style or essential meaning.

Illustrations

Authors are asked to plan to write their articles so that illustrations are not essential. The physical and editorial format of *Rehabilitation Literature* will not permit usually the use of photographic illustrations or a substantial number of tables or charts. When an author finds that illustrations are required for his paper he should consult the Editor immediately.

References and Footnotes

The author is asked to compile his references in a form that is consistent with a style to be found in the journals of his own profession. That the citations be complete and accurate is the responsibility of the author and is not one that the Editor can assume. The list of references should be typed as a separate section so that it may be published at the end of the article. On the other hand, footnotes, if any, should appear on the same page of the manuscript in which reference is made to them.

Information About the Author

When the manuscript is sent to the Editor, it should be accompanied by a biographical data sheet containing information about the author's education, professional work, and membership in professional organizations. This information will be used in the preparation of a short statement identifying the author to appear on the first page of the published article. A glossy photographic print of the author, suitable for reproduction, should be included for possible use, if one is available.

EARL C. GRAHAM
Editor

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.

AMPUTATION

701. Chapman, Carrie E. (13th and Harrison Sts., Oakland 12, Calif.)

Follow-up study on a group of older amputee patients, by Carrie E. Chapman (and others). *J. Am. Med. Assn.* July 18, 1959. 170:12:1396-1402.

Extensive data gathered in a follow-up study of the post hospital adjustment of 51 amputees, all of whom were 55 years of age or older at the time of surgery, is presented. Major areas investigated were physical status, mortality trends, personal and socioeconomic adjustment, the extent to which a prosthetic appliance had been prescribed, and actual use of the prosthesis. In the age group represented, it was not surprising to find a prevalence of chronic conditions and of multiple diagnoses; the most frequent complication necessitating amputation was gangrene for slightly less than two-thirds of the group. Favorable adjustment appeared to be related to less extensive changes in physical condition, mode of living, ability to ambulate, and restrictions on activities. Analysis of the data convinced the authors that it was worth while to have given these older amputees the benefit of the use of prostheses with assistive devices since it enabled them to remain more independent.

702. Simmel, Marianne L. (Duke Univ., Durham, N.C.)

Phantom experiences in mental defective amputees. *J. Abnorm. and Soc. Psych.* July, 1959. 59:1:128-130.

From a survey of the literature on phantom-limb experiences, the author found a series of myths that apparently have never been systematically tested. One such—that mental defective amputees have no phantoms—was subjected to study. A group of 26 mental defectives, 25 of whom represented the entire amputee population of five state institutions, were interviewed. Apparently reliable information was given by 12, only one of whom reported no phantom sensations. For 8 of the 12 patients, there was definite evidence of phantoms; in 3, fairly consistent information of intermittent phantom experiences was given. It was not possible to establish a relationship between phantom experiences and MA or IQ at the time of the amputation or of the interview. However, educational achievement was significantly greater in those patients giving consistent and positive reports of phantom experiences than in those who did not. The author believes it is not totally unlikely that phantoms develop even at quite low levels of cognitive maturity, but that they do not persist as long as in normal amputees and are not remembered by defective patients.

AMPUTATION—PHYSICAL THERAPY

703. Magato, Richard S. (V.A. Center, Dayton, Ohio)

Three year study of lower extremity amputees at a

Veterans Administration center. *Phys. Therapy Rev.* July, 1959. 39:7:461-466.

An analysis and evaluation of findings in a three-year study of 93 lower extremity amputees treated in the physical therapy department of the Veterans Administration Center, Dayton. Purpose of the study was to determine effectiveness of the program primarily for patients in the older age group; 73 percent were over age 50. Conditioning the stump so that prosthetic fitting difficulties can be kept to a minimum presents a major problem; other physical and psychological difficulties influence the patient's ability to adjust to the prosthesis. Successful results have been achieved, however, in aged amputees handicapped by several disabling diseases. Methods used in the treatment programs and data about the results are discussed.

APHASIA

704. American Speech and Hearing Association (1001 Connecticut Ave., N.W., Washington 6, D.C.)

The concept of congenital aphasia from the standpoint of dynamic differential diagnosis; a symposium, Thirty-Fourth Annual Convention . . . November 17, 1958, New York. Washington, D.C., The Assn., 1959. 32 p.

Contents: Pediatric aspects, Spencer F. Brown.—Psychological aspects, Edmund C. Neuhaus.—Psychiatric aspects, Lauretta Bender.—Neurological aspects, Isabelle Rapin.—Hearing and speech aspects, Louis M. DiCarlo.

Papers for the Symposium were prepared for the scientific sessions of the 1958 convention of the American Speech and Hearing Association and were edited by Dr. Brown. In his foreword he notes that all five speakers appeared to doubt the validity of the concept of congenital aphasia. Such agreement was all the more remarkable, he believed, in view of their widely divergent backgrounds, training, experience, and professional specialization. Emphasis in all discussions was on the problems of differential diagnosis.

ARCHITECTURE (DOMESTIC)

705. California. Senate. Interim Committee on Housing and Recreational Needs of the Elderly

Report of the . . . 1959. Sacramento, The Senate, 1959. 93 p. tabs.

The first legislative committee report in California to deal specifically and exclusively with housing problems of the aged, it contains four chapters covering the detailed facts necessary for understanding the problem within the state, as well as the Committee's general observations, findings, conclusions, and recommendations. Data were obtained through a questionnaire survey of all California cities and all social science or sociology departments of colleges and universities in the state. Comments from pri-

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vate individuals and organizations were also solicited. Information is given on estimates of and predicted trends in the aged population in California, characteristics of this age group, living arrangements and costs, and types of care needed, including that needed for persons with long-term illness. Half the report is devoted to a summary of the survey findings and includes letters received from city officials and interested individuals and organizations in regard to housing and recreational needs of the elderly and how they are being met.

The report is available from Miss Barbara Rosien, Coordinator, Senate Interim Committee on Housing and Recreational Needs of the Elderly, P.O. Box 2316, Terminal Annex, Los Angeles 54, Calif.

706. U. S. Housing and Home Finance Agency

Housing the elderly; a review of significant developments. Washington, D.C., The Agency, 1959. 38, (8) p. architectural drawings, tabs. Mimeo.

A report prepared by the Housing and Home Finance Agency of the federal government, it presents a summary of the factors influencing housing requirements, elderly persons' choice of living arrangements in four phases of aging, types of housing needed, demands for institutional care, and programs under state and federal aid to the aging. A large portion of the report gives specific examples of housing developed under the auspices of nonprofit religious and fraternal groups, local housing authorities, and private builders. Tables listing nonprofit rental housing projects aided by the Federal Housing Administration that have been approved or are in the planning stages are included.

The report is available from Norman P. Mason, Administrator, Housing and Home Finance Agency, Washington 25, D.C.

AUDIOMETRIC TESTS

707. Kodman, Frank, Jr. (*Audiology Clinic, Univ. of Kentucky, Lexington, Ky.*)

Psychogalvanic skin response audiometry with severe mentally retarded children, by Frank Kodman, Jr., Arthur Fein, and Ashley Mixson. *Am. J. Mental Deficiency.* July, 1959. 64:1:131-136.

A report of a study of the clinical efficiency of psychogalvanic skin response audiometry in the evaluation of organic hearing sensitivity in severely retarded children who are unable to respond accurately to standard subjective hearing tests. Subjective speech audiometry was used as an additional measurement. Twenty-eight children from the Kentucky Training Home were tested using two reinforcement schedules. Results suggest the value of using speech audiometry as an adjunct to P.G.S.R. audiometry with mentally retarded children who have a mental age below five years. Objective speech audiometry should also be considered. Methods and apparatus used in testing are discussed. Areas for further research are suggested.

BLIND—DIRECTORIES

See 691.

BRACES

See 723.

BRAIN INJURIES

708. Knobloch, Hilda (*561 S. 17th St., Columbus 5, Ohio*)

Syndrome of minimal cerebral damage in infancy, by Hilda Knobloch and Benjamin Pasamanick. *J. Am. Med. Assn.* July 18, 1959. 170:12:1384-1387.

A discussion of clinical aspects of the syndrome of minimal cerebral damage in infancy and its importance in prognosis, especially in identifying infants who might later develop learning and behavioral difficulties. This report is based on a study of 500 premature and 492 full-term control infants at 40 weeks of age. The neuropsychiatric developmental examination of Gesell and Amatruda and the physical examination were made by the pediatrician; it was found that the amount of neurological damage increases as the birth weight of the infant decreases. A correlation was found to exist between the degree of abnormality diagnosed at the examination and certain historical material reported by the mother concerning the infant's behavior in the first month and up to the time of the examination. Findings of adaptive functioning in infants at 40 weeks have been noted to correlate well with maturity levels at three years of age. The physician should be aware of the importance of taking a careful history of early behavior and development in order to evaluate the nature of neuropsychiatric disability at any age. The possibility that infants with difficulties produce tensions in mothers, rather than the reverse, should be considered seriously.

BRAIN INJURIES—ETIOLOGY

709. Courville, Cyril B. (*Los Angeles County Hosp., 1200 N. State St., Box 76, Los Angeles 33, Calif.*)

Antenatal and paranatal circulatory disorders as a cause of cerebral damage in early life. *J. Neuropathol. and Experimental Neurology.* Jan., 1959. 18:1:115-140.

Cerebral lesions originating in early life that are apparently the cause of cerebral palsy, mental deficiency, and epilepsy were studied in an attempt to determine their etiology and pathogenesis. The writer gives his reasons for believing these lesions were caused by generalized or localized disturbances in the circulation. Types of recognized circulatory disorders of the antenatal, perinatal, and postnatal periods are discussed and specific types of residual lesions are considered individually. Dr. Courville bases his evidence on opinions of previous investigators, his own experience in the field of anoxic and ischemic lesions of the brain, and on results of animal experimentation. Bibliography of 82 references.

CAMPING

710. Blaszkowska, Janina (*Wroclaw Rehabilitation-Orthopaedic Sanatorium, Wroclaw, Poland*)

The role of camping in the psychological aspect of rehabilitation. *Occupational Therapy.* June, 1959. 22:6:19-22.

Rehabilitation center personnel assume that every disabled person does want to attain his maximum potential but, because the rehabilitation process is a lengthy one, the young patient often fails to realize the necessity for cooperation on his part. He tends to make others responsible for his failures and expects society to fulfill his

every demand. Such attitudes carried over into normal social life can be harmful to the disabled person. Adolescents between the ages of 12 and 18 at the Rehabilitation-Orthopaedic Sanatorium in Wroclaw are provided summer camping experiences at the seashore or in the mountains. Such activity makes the children realize the value of physical skills gained through therapeutic exercises given at the Center. Contact with the world outside the Sanatorium is a socializing experience; adolescents begin to realize that success lies in overcoming their difficulties and not in avoiding or succumbing to them.

CEREBRAL PALSY

711. Cerebral Palsy Bul. Spring, 1959. No. 5

This issue devoted to papers and discussions at the Oxford Study Group on Child Neurology, sponsored by the National Spastics Society, Sept. 21-27, 1958.

Contents: Present state of child neurology, Cyrille Koupernik.—The characteristics of spasticity in children, Ronald MacKeith.—Muscle tone and posture in infancy, T. T. S. Ingram.—Educational disabilities of cerebral palsied children attending Local Education Authority schools, R. V. Saunders.—Neurological examination of the newborn according to the work of Prof. Andre Thomas, Paul E. Polani.—Definition of cerebral palsy, R. C. MacKeith, I. C. K. Mackenzie, and P. E. Polani.—On discussing terminology and classification, M. L. Johnson Abercrombie.—The Little Club memorandum on terminology and classification of "cerebral palsy," Ronald C. MacKeith, Ian C. K. Mackenzie, and Paul E. Polani.—Comments on the Little Club memo: 1. Classification of cerebral palsy; yesterday and today, Paul E. Polani. 2. The classification of cerebral palsy, Ronald S. Illingworth. 3. Our point of view on the standardization of terminology, Adelaide Grisoni-Colli. 4. Some remarks on terminology and classification, Sven Brandt. 5. The use of neurological terms in cerebral palsy studies, Ian C. K. Mackenzie.—Working-Party discussion; report, T. T. S. Ingram.—Nomenclature and classification; general report and comment, P. E. Polani.—General discussion of the Little Club memo.

CEREBRAL PALSY—DIAGNOSIS

712. Rosner, Samuel (*Medical Arts Bldg., 1882 Grand Concourse, Bronx 57, N.Y.*)

Complicated cerebral palsy; surgical pathologic aspects. *J. Internat. Coll. Surg. Mar., 1959. 31:3:315-322.*

Cerebral venous angioma in the region of the sylvian fissure was observed unilaterally in 49 of 51 children with complicated cerebral palsy who underwent craniotomy. Of the remaining 2 patients, one had a subarachnoid cyst compressing the fourth ventricle; the other, premature closing of the fontanel. Postmortem observations of the brains of five who died were consistent in all cases studied. There was no evidence of porencephaly nor any other marked abnormality detected grossly or microscopically. It is believed that removal of the pathologic tissue at operation offers the child a chance for recovery. Of the 46 children who survived the operation, all have shown improvement; one or two are even at their normal grade level at school. Five case reports, with postmortem findings, are included. Areas of improvement in the surviving children are mentioned.

CEREBRAL PALSY—EQUIPMENT

713. Robertson, Gordon G. (*614 S. Flood St., Norman, Okla.*)

Design and measurement of training chairs for the cerebral palsied child. *Phys. Therapy Rev. Aug., 1959. 39:8:538-542.*

Special training or relaxation chairs designed to the individual child's requirements have been constructed at the Cerebral Palsy Institute, Norman, Okla. Two types—standard and bucket chairs—are described, with specifications for their construction. The form sheet used at the Institute for recording exact measurements to be followed in construction is included. Brief recommendations are offered for the care and cleaning of the chair and on explanations to be given parents on the chair's use.

CEREBRAL PALSY—PHYSICAL THERAPY

714. Kabat, Herman (*Bur. of Rehab. and Services for the Aging, Dept. of Social Welfare, 40 Fountain St., Providence, R. I.*)

Athetosis; neuromuscular dysfunction and treatment, by Herman Kabat and Margaret McLeod. *Arch. Phys. Med. and Rehab. July, 1959. 40:7:285-292.*

Contrary to most opinions, it is the authors' belief that training of voluntary relaxation in patients with athetosis has very limited value in improving their functional performance. Paresis of voluntary movement is a constant finding in athetosis and often limits ability to perform the most basic movements. Better understanding of the neuromuscular dysfunction is used as the basis for a different and more effective approach to treatment. Modified technics of proprioceptive facilitation are used; adequate assessment of isotonic, isometric, and eccentric function in every part of the range of motion should be made. Athetoid irradiation resulting from resistive exercise can be ignored since it decreases as voluntary motion improves. Characteristic athetoid patterns of movement are described and adapted proprioceptive neuromuscular facilitation technics outlined briefly.

715. Stimson, Cyrus W. (*Letchworth Village, Thiells, N.Y.*)

The treatment of cerebral palsy in mentally retarded patients using high-frequency, low voltage, electric currents. *Am. J. Mental Deficiency. July, 1959. 64:1:72-80.*

A report published in 1957 on the use of high-frequency waves in the treatment of spastic mental defectives prompted the current experiment. Application of filtered, amplitude modulated, unidirectional currents ("sedac") to the heads of 15 mentally retarded cerebral palsied patients caused no marked or sustained relief of spasticity or significant improvement in ability to perform daily living activities, as compared with a control group. A series of 12 treatments, each lasting half an hour, was given each of the experimental group. Some slight temporary relief of spasticity resulted from use of this type of electrotherapy. Application of current directly to the involved extremities also caused a temporary but more noticeable and consistent reduction in spasticity than bite temporal application. It is believed that any beneficial results obtained are probably due to an effect on peripheral

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afferent nerves that, in turn, causes secondary effects in the central nervous system. 23 references.

CEREBRAL PALSY—SURVEYS—DENMARK

716. Danish Society for the Welfare of Spastics

Cerebral palsy in Denmark; a survey by the . . . compiled by Mogens Fog and Preben Plum. New York, Internatl. Soc. for the Welfare of Cripples, 1959. 12 p. tabs. Mimeo.

A report of a countrywide survey to determine incidence of the disease, causes and forms, types of treatment patients had received, and the probable need for treatment at the present time. Social status, education, and training were investigated and health insurance and welfare organizations providing aid for the cerebral palsied were assessed. The report covers 2,600 patients born between 1925 and 1953. Analysis of the data revealed that every year approximately 150 children in Denmark are born with symptoms of cerebral palsy. From 10 to 20 of this number die before reaching their fifth year. Recommendations for the extension and addition of new facilities to serve the cerebral palsied are given in conclusion.

Copies of the report are available free of charge from the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N.Y.

CHILDREN (DEPENDENT)

717. American Academy of Pediatrics

Adoption of children. Evanston, Ill., The Academy, 1959. 60 p.

A manual to inform physicians, especially pediatricians, on the basic principles in regard to adoption, their role in this area, the medical, social, and legal aspects of adoption, and the physician's responsibilities to the natural parents, the child, and the adoptive parents. Chapter 6 discusses special problems presented by handicapped children proposed for adoption. A glossary of terms, a 10-page bibliography, a directory of selected organizations publishing reference material listed, and an index add to the manual's usefulness.

Available from American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill., at \$1.00 a copy.

CHILDREN'S HOSPITALS

See 694.

CHRONIC DISEASE—INSTITUTIONS

See 693.

DEAF—INSTITUTIONS

718. Kent, Margaret S. (*Maryland School for the Deaf, Frederick, Md.*)

Administrative procedures concerning admission of new students to residential schools for the deaf. *Am. Annals of the Deaf*. May, 1959. 104:3:271-276.

Not all children who fail to talk spontaneously in the normal manner are candidates for schools for the deaf. Mental deficiency, emotional disturbance, brain damage, and central nervous system damage complicate the problem of deciding which children could benefit from the educational program offered in a school for the deaf. If the

child's condition cannot be diagnosed in the medical clinic or hospital, the school should provide a preliminary evaluation prior to the child's admission. In addition to providing an estimate of the child's potential, the initial assessment is valuable to the administrator in assigning class placement should the child be admitted. Periodic reassessment of residual hearing will be an aid in planning the individual child's educational program. Knowledge of the etiology of the child's deafness can further understanding of the atypical behavior some deaf children exhibit. Methods for individualized teaching are discussed briefly.

DEAF—RECREATION

See 757.

DEAF—STATISTICS

719. Frisina, D. Robert (*Hearing and Speech Center, Gallaudet College, Washington, D.C.*)

Statistical information concerning the deaf and hard of hearing in the United States. *Am. Annals of the Deaf*. May, 1959. 104:3:265-270.

A paper prepared for distribution at the Working Conference on Health Aspects of Hearing Conservation, Washington, D.C., in May, 1959, it presents data on the estimated number of deaf and hard of hearing persons in the United States, facilities for school-age deaf (by type of educational facility), speech and hearing clinics and the various settings in which they operate, and estimates of multiple handicaps found in association with deafness, as reported in educational facilities for school-age deaf. Implications of the data are that the number of hearing-handicapped persons appears to be increasing, that the increasing incidence of multiple handicaps will necessitate greater attention from medical and nonmedical specialties, and that earlier detection of hearing impairment has created a shortage of trained personnel to meet the increased demand for services. The article also contains a listing of information centers, indexing centers, and journals pertaining to education of the deaf in the United States.

DRUG THERAPY

720. Craft, Michael (*Balderton Hosp., Newark, N.J.*)

Mental disorder in the defective; the use of tranquilizers. *Am. J. Mental Deficiency*. July, 1959. 64:1:63-71.

In same issue: Effects of prochlorperazine therapy on educability in disturbed mentally retarded adolescents, by Anna C. Mitchell (and others). p. 57-62.

Section One of the article reviews the literature on use of tranquilizers in the mental deficiency field up to 1958. Section Two describes the results of trials conducted by the author to assess the value of tranquilizers in the treatment of hyperactivity, destructiveness, and aggressiveness in idiots and imbeciles below IQ 38 and behavior problems in patients with IQ over 39. The latter group had personality disorders or frank mental illness. In the author's opinion, prochlorperazine is currently the drug of choice for hyperactivity syndromes in low-grade defectives. Benactyzine has been found effective in decreasing activity in high-grade defectives with emotionally unstable personalities. 31 references.

The article by Anna C. Mitchell and her coauthors (*Porterville State Hosp., Porterville, Calif.*) is a report

of an experiment with prochlorperazine (Compazine) in behaviorally disturbed mental retardates between the ages of 12 and 17 and with IQ's above 39. The experimental group and a control group were taught together in academic school classes for six months. It was hypothesized that patients receiving Compazine would improve in intellectual, social, motor, and behavioral spheres and that such an increment in basic capacities would be related to an increase in school achievement. None of the hypotheses was substantiated; both groups achieved equally in the classroom. Results offer no evidence that the drug, administered over a short period of time without accompanying psychotherapy, will produce an increment in educability.

721. Sokolow, Jack (79-01 Broadway, Elmhurst 73, Queens, N.Y.)

The effect of iproniazid on the rehabilitation of disabled persons with low motivation, by Jack Sokolow and Carmine Casella. *J. Chronic Diseases*. July, 1959. 10:1: 72-79.

Inadequate or insufficient motivation prevents many disabled persons from actively participating in the rehabilitation program. The majority of blocks in this area are of a psychological nature; individual and group psychotherapy has been used with varying degrees of success to increase motivation. The process has proved too time-consuming, however, to be practical. Promising studies on the "energizing" properties of iproniazid suggested its use in the pilot study reported here. A sample of disabled patients, average age 56.2 years, was divided into an experimental group (11 patients given the drug) and a control group (9 given a placebo). The drug was given for a six-week period. Both groups showed gains in performance but the experimental group showed much greater progress than the control group. Neither group showed appreciable change in motivation as clinically determined or on psychological testing. Although increased performance of the patients was not reflected in psychological tests, it is believed that rehabilitation seems to be advanced through use of the drug. Possible reasons for the negative psychological findings are discussed. 19 references.

EMPLOYMENT

722. Minnesota. University. Industrial Relations Center

Minnesota studies in vocational rehabilitation: VII. Factors related to employment success, by Vera Myers Schletzer (and others). Minneapolis, The Center, 1959. 32 p. tabs. (Bul. 27, May, 1959)

Presents information from further analysis of data obtained in a survey of the physically handicapped population of Minnesota by the Industrial Relations Center for the State Legislature. (Previous bulletins were listed and annotated in *Rehab. Lit.*, Mar., 1959, #268; and Dec., 1958, #1300.) Interview data on a statewide sample of 255 physically handicapped persons of labor force age were analyzed as to age, sex, marital status, education, type of disability and cause, present status of employment, and wage level. Such factors as sex, age at time of disablement, nature of the disability, education, and economic pressures were found to be related to employment status.

Implications of the findings for determining priorities in the expansion of rehabilitation services and for counseling and placement purposes are discussed.

Available free from the Industrial Relations Center, University of Minnesota, Minneapolis 14, Minn., as long as the supply lasts.

HEMIPLEGIA

723. Brennan, J. Brewster (Dept. of Phys. Med., St. James Hosp., London, England)

Response to stretch of hypertonic muscle groups in hemiplegia. *Brit. Med. J.* June 13, 1959. 5136:1504-1507.

Chance observation of the effects of splinting to prevent contracture of the knee in a hemiplegic patient led to the present study. The original patient's knee had been habitually held in 90 degree flexion by marked tonic spasm. The splint, worn constantly, had been comfortable to wear and had enabled him to walk. Hypertonus in the hamstrings had been abolished and voluntary extension, previously absent, could be performed against resistance. Fourteen hemiplegic patients each had one or more flexor muscle groups, habitually held in a state of contraction by tonic spasm, subjected to constant stretching by means of splints. In every case the treated muscle groups showed greater improvement than did neighboring unstretched muscles. Although the number of muscle groups studied was small, the author believes that 12 weeks of constant stretch and 8 weeks of intermittent stretch are required to give lasting abolition of degrees of hypertonus in the presence of moderate spasm. Patients with other diseases of the central nervous system were also treated. Results obtained suggest that both clonic and tonic muscle spasm associated with cerebral palsy, disseminated sclerosis, and tuberculous meningitis may be relieved by judicious periods of stretch.

HEREDITY

724. American Eugenics Society

Special reproductive patterns in the presence of psychiatric family problems (presented at the International Conference on Differentiation in Current Mating and Fertility Trends, sponsored by . . . 1959). *Eugenics Quart.* June, 1959. 6:2:112-147.

Contents: Introductory remarks by Chairman, Paul H. Hoch.—Fertility trends in some types of mental defects, J. A. Böök.—Mating and fertility patterns in families with early total deafness, John N. Rainer and I. Lester Firschein.—Discussion, W. Edwards Deming.—Families with manic-depressive psychosis, Aubrey Lewis. — Discussion, Ørnulv Ødegaard.—Mating and fertility patterns in families with schizophrenia, Erik Essen-Möller.

Papers from the Proceedings of the Conference, presented at the afternoon session, Feb. 14, 1959, dealt with important problems of mating and fertility patterns, an understanding of which should lead to a better formulation of eugenic principles. The relationship of these patterns to functional psychoses and to mental retardation was given special consideration.

HOME ECONOMICS

See 698; 700.

ABSTRACTS

LARYNGECTOMY

725. Restoration of speech after laryngectomy. *Lancet*. July 11, 1959. 7089:31.

In same issue: (Letters to the Editor) Appliances for the production of artificial voice, William MacGregor and R. V. Tait. p. 38.

For those persons who cannot master the technics of esophageal speech following laryngectomy, the artificial larynx and, more recently, electronic appliances are providing mechanical assistance for voice production. A newly devised surgical procedure is also described that aids in the acquisition of esophageal speech. The two letters describe recently developed aids—one an electric vibrator of the fixed-frequency pattern; the other an electrically vibrated diaphragm built into the palate of an upper dental prosthesis. Sources for additional information on the two appliances are included.

MENTAL DEFECTIVES

726. Edward R. Johnstone Training and Research Center

Institute on mental retardation, Summer 1958, presented by . . . Trenton State College, Trenton, New Jersey. Bordentown, N. J., The Center, 1959. 42 p. (Johnstone bul., Vol. 1, no. 1) Mimeo.

Contents: Contributions of basic psychological research to the education of the mentally retarded, Gordon N. Cantor.—Characteristics of educable mentally handicapped children, Herbert Goldstein.—The multidisciplinary approach to special education, Herbert Rusalem.—Evolving curriculum concepts in the education of the mentally retarded, I. Ignacy Goldberg.

Four of the six papers presented at the Institute on Mental Retardation, a six-week program supported by the National Institute of Mental Health and co-sponsored by Trenton State College and the Edward R. Johnstone Training and Research Center. The Institute was held in conjunction with four workshops in the psychological and educational approaches to mental retardation, offered by Trenton State College.

MENTAL DEFECTIVES—DIAGNOSIS

See 707.

MENTAL DEFECTIVES—EMPLOYMENT

727. Rosenblum, Sidney (*Wayne County Training School, Northville, Mich.*)

A survey of farm and dairy operations in institutions for the mentally retarded, by Sidney Rosenblum, Casimir Przbyl, and Pasquale Buoniconto. *Am. J. Mental Deficiency*. July, 1959. 64:1:87-91.

Scope, purpose, and procedures of institutional farm and dairy operations for the mentally retarded were investigated in a survey canvassing opinions from administrators and farm supervisors. The desirability of continuing such programs, considering the increased maintenance costs and growing urbanization of the United States, was questioned. Of the 82 public institutions for the mentally subnormal that were sent questionnaires, 68 responded; 57 of these reported an active farm-dairy program. In general, data indicated that such programs are worth while and no trend toward discontinuing them was evident. Conclusions drawn from an analysis of the data are given.

MENTAL DEFECTIVES—MEDICAL TREATMENT

See 702; 715; 720.

MENTAL DEFECTIVES—PARENT EDUCATION

728. Watson, Ernest H. (1313 E. Ann St., Ann Arbor, Mich.)

The family physician and the mentally retarded child. *Postgrad. Med.* Mar., 1959. 25:3:301-309.

Accurate diagnosis of congenital defects during the early neonatal period is more difficult at the present time due to the short time the baby spends in the hospital. There are signs or symptoms, however, that the physician should watch for. As long as he only suspects the presence of abnormality, he should not arouse parental fears. Subsequent observation of the infant's development will confirm or deny earlier suspicions. Mental retardation can often be detected as early as three months of age. Enlisting the aid of other professional services, the physician may arrive at more accurate diagnosis of degree or type of mental retardation. Counseling with parents of the child who has a serious defect requires time in order that the parents may thoroughly understand the implications of the diagnosis. Hereditary aspects of mental deficiency must be considered in answering parents' questions. Dr. Watson closes with a list of questions commonly asked by parents; answers are based on views and opinions developed at conferences and round-table discussions of the subject.

729. Zuk, G. H. (*St. Christopher's Hosp. for Children, Philadelphia, Pa.*)

The religious factor and the role of guilt in parental acceptance of the retarded child. *Am. J. Mental Deficiency*. July, 1959. 64:1:139-147.

In same issue: A procedure for evaluating parental attitudes toward the handicapped, John R. Thurston. p. 148-155.

In a study to determine factors affecting the kind of adjustment parents will make to a retarded child, a number of variables were compared, specifically in relation to acceptance of the child by the mother. Guilt feelings have often been implicated as a major factor impeding adjustment and it has been suggested that religious background influences the kind and degree of guilt feelings. Because major religions handle the guilt concept in different ways, it was thought a relationship might exist between religious background and levels of acceptance and adjustment. Findings provide some evidence of such a relationship. Catholic mothers were found to be more acceptant than non-Catholic mothers. An implication of the study is that due consideration should be given to the religious factor during psychotherapeutic work with parents. Skillful probing of guilt feelings is considered an initial step toward improving level of acceptance of the child.

Dr. Thurston (*Wisconsin State Coll., Eau Claire, Wis.*) offers a psychological device (the Thurston Sentence Completion Form) useful in determining the attitudes and emotional reactions of parents of handicapped children. It reveals their individual reactions and concerns, as well as their viewpoints on satisfactions and frustrations of the handicapped child, reactions of siblings, community, friends, and neighbors, hopes and expectations for the child, and impressions of the institution and its staff.

REHABILITATION LITERATURE

Administration of the test is simple and requires a minimum of supervision. Institutions and rehabilitation agencies should find the form useful in determining social and emotional problems that might seriously interfere with effective treatment and rehabilitation of the handicapped.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

730. Gunzburg, H. C. (*Monybull Hall Hosp., Birmingham, England*)

Earl's moron-battery and social adjustment. *Am. J. Mental Deficiency*. July, 1959. 64:1:92-103.

A description of a battery of tests originated by C. J. C. Earl in 1940 that reflects the degree of instability occurring in emotionally abnormal mental defectives. An evaluation of the usefulness of the battery was attempted through a study of the social histories of 44 certified mental defectives in relation to psychographs obtained from the moron-battery 6 to 9 years previously. It was found that the history of subsequent social adjustment, especially the type of discharge and the continued hospitalization, agreed well with the prognosis based on the psychographs. It would appear that the battery has value in predicting social adjustment.

MENTAL DEFECTIVES—SPECIAL EDUCATION

731. Dawe, Ann

Progress in curriculum and method with mentally handicapped children. *Am. J. Mental Deficiency*, July, 1959. 64:1:19-23.

A survey of the literature pertaining to curriculum and methods for educable and trainable mentally handicapped children, published during the past 10 years, revealed serious omissions and deficiencies. Three areas of development in curriculum and method have received increased attention—speech therapy, vocational preparation, and the development of training programs for severely retarded children. No article on the teaching of arithmetic has appeared since 1948; articles on social studies and science are all but absent in professional journals. Other articles at a minimum are those on physical education, recreation, homemaking, and manual arts. Some attention has been given driver education and sex education. Those on music, language arts, and arts and crafts show up poorly in relation to their importance in educational programs for the mentally handicapped. Of the eight articles dealing with method, only three discussed particular techniques; the remainder were general enough to be considered more of a contribution to educational philosophy. Urgently needed at present is a more dynamic approach to curriculum with specific suggestions for implementation.

732. Pollock, Morris P. (*Pollock School, 28 Alton Pl., Brookline, Mass.*)

A private school curriculum for trainable children. *Am. J. Mental Deficiency*. July, 1959. 64:1:24-28.

A discussion of the basic techniques of teaching trainable mentally handicapped children, as practiced at a private residential school. Education is planned on three "plateaus" of learning—those from 5 to 9 years of age comprise the lowest level; the second from the age of 9 to

14; and the third from age 14 to the time of employment. Help and assistance are given the children until desirable habits and skills are firmly established. The length of time spent on each step in learning depends upon the individual child's personality. Objectives of the three stages of educational development are discussed; specific methods found to be useful with these children are mentioned.

733. Rosenzweig, Louis (*Brooklyn Coll., Brooklyn, N.Y.*)

How far have we come? *Am. J. Mental Deficiency*. July, 1959. 64:1:12-18.

Trends in curriculum development, educational philosophy, teaching methods, classroom management, the development of evaluation instruments, and the growth of related services during the past five years are discussed in relation to education of trainable mentally defective children (below IQ 50).

MENTAL DEFECTIVES—SPEECH CORRECTION

734. Irwin, Ruth Beckey (*Ohio State Univ., Derby Hall, Columbus 10, Ohio*)

Oral language for slow learning children. *Am. J. Mental Deficiency*. July, 1959. 64:1:32-40.

Goals in speech therapy for the slow-learning child must be simple and realistic; the improvement of language is more to be desired than the correction of specific sound defects. Guides for speech therapy and language development and approaches to therapy with the slow-learning child are discussed. Outlines of lesson plans for the stimulation of talking, for auditory training, and for the correction of specific speech sounds are included. It is suggested that the classroom teacher is the ideal person to help the slow-learning, language-handicapped child. A coordinated speech program in which parents, teacher, speech therapist, and all those associated with the child cooperate will achieve the best results.

MENTAL DISEASE—PROGRAMS

See 750.

MENTAL DISEASE—RECREATION

735. Recreation for the Ill and Handicapped. June, 1959. 3:3.

Contents: President's message: A philosophy of institutional recreation, Steve Chiovaro.—A method of establishing rapport with mental patients in state hospitals, Lorenzo A. Carter.—Study of basketball skills of the neuropsychiatric patient; individual and team play, Sports Staff, V. A. Hospital, Salisbury, N.C.—The initiation of an intensive recreational therapy program for a closed ward of male psychiatric patients, Louis Lehmann.—Group camping as a therapeutic experience with psychiatric patients; Part I, Ora R. Ackerman, Spiro B. Mitsos, and A. Margaret Seymour.—Modifying a recreational program for regressed women in chemotherapy; a report, Marianne E. Musgrave.—Treatment versus terminology, Ira J. Hutchison, Jr.

Recreation for the Ill and Handicapped is published quarterly by the National Association of Recreational Therapists; treasurer is Virginia L. Dobbins, Bryce Hospital, Tuscaloosa, Ala. Subscription rate is \$3.00 a year.

ABSTRACTS

MUSCLES—TESTS

736. Wintz, Margaret M. (429 N. Mariposa Ave., Los Angeles 4, Calif.)

Variations in current manual muscle testing. *Phys. Therapy Rev.* July, 1959. 39:7:466-475.

This article, adapted from an M.A. thesis, Stanford University, 1957, compares and analyzes variations in manual muscle testing technics for 6 of the 11 muscles or muscle groups in the shoulder girdle and hip regions. Those reported here are used for testing the anterior deltoid, serratus anterior, middle trapezius, lower trapezius, tensor fascia lata, and the internal rotators of the hip. Basic kinesiological considerations were reviewed in relation to differences in positioning, direction of the test movement, and application of manual resistance in giving the tests. The author made a questionnaire survey to obtain information from physical therapists on their individual technics of testing and the record forms used.

MUSCULAR DYSTROPHY

See 738.

MUSIC THERAPY

737. Joseph, Harry (815 Park Ave., New York 21, N.Y.)

The therapeutic use of music with "treatment resistant" children, by Harry Joseph and Evelyn Phillips Heimlich. *Am. J. Mental Deficiency.* July, 1959. 64:1:41-49.

Describes the use of music therapy with a group of children in a residential school, a unit of the Jewish Child Care Association of New York. All had received an average of two years' treatment in music therapy after other psychotherapeutic attempts had failed. Methods, clinical experiences, and theory of music therapy are presented. Three case histories illustrate the therapeutic benefits achieved. A scale devised for the evaluation of results is included. All members of the staff—teachers, psychologists, social workers, psychiatrists, and house counselors—participated in evaluations.

738. Korson, Frances

Canadian pilot study in music therapy with muscular dystrophy children. *Canad. J. Occupational Ther.* June, 1959. 26:2:45-49.

A report of a project sponsored by the Canadian Dystrophy Association and conducted at the Home for Incurable Children, a hospital school, and at Lyndhurst Rehabilitation Lodge. An educational and recreational music program for children with muscular dystrophy proved to have therapeutic benefits. Although the physical effects of the program were difficult to evaluate, psychological changes were quite evident. Activities comprising the program are discussed. Music should prove to be a definite source of comfort and satisfaction to these children as they become progressively worse and are bed-fast.

NEUROLOGY

See 695, 696.

NUTRITION

See 741.

OCCUPATIONAL THERAPY

See 698.

OLD AGE

739. Bortz, Edward L. (Lankenau Hosp., Lancaster Ave. and City Line, Philadelphia 31, Pa.)

Major issues of aging, by Edward L. Bortz and Walter M. Bortz, II. *G.P.* July, 1959. 20:1:84-95.

Medical, social, and economic aspects of aging are receiving increased attention; medicine's share in the problem is the control of the diseases and deterioration that come with age. Biologic, physiologic, psychologic, social, and emotional aspects of the aging process are discussed, with recommendations for the development of a positive philosophy of physical and mental health conducive to increasing the productiveness of old age. Doctors should assume a leadership role in building new social patterns that recognize the potential of aging persons.

OLD AGE—EMPLOYMENT

740. McFarland, Ross A. (Boston School of Public Health, 1 Shattuck St., Boston 15, Mass.)

Job placement and adjustment of older workers; utilization and protection of skills and physical abilities, by Ross A. McFarland and Frank Randolph Philbrook. *Geriatrics.* Dec., 1958. 13:12:802-807.

Hanman's "Specific Method" for effective job placement appears to be the most satisfactory procedure evolved to date for matching the physical requirements of the job with the physical capacities of the worker. A brief description of the method is given with a comparison of the relative advantages and disadvantages of other known placement methods. The Specific Method is applicable not only to older workers, but to all workers with varying degrees of physical ability. Gainful employment of older workers, however, has become increasingly important due to their growing numbers. In addition to its usefulness as an employment technic, the Profile of Physical Abilities (a form for recording physical capacity) can be filled out as a prescription for the individual geriatric or convalescent patient in order to guide him through his daily activities. Descriptions are sufficiently precise so there is little opportunity for misunderstanding among the industrial physician, placement counselor, and workers.

OLD AGE—INSTITUTIONS

See 693.

OLD AGE—RECREATION

See 705.

PARAPLEGIA—EQUIPMENT

741. Granger, Carl V., Jr. (Letterman Army Hosp., San Francisco, Calif.)

Feeder apparatus for the supine quadriplegic, by Carl V. Granger, Jr., and Donna J. Day. *Am. J. Phys. Med.* June, 1959. 38:3:89-94.

Describes the construction of equipment that enables quadriplegic patients, especially those with cervical root

injury at the C5 and C6 levels, to feed themselves while lying supine. The apparatus has been used with four such patients in various stages of recovery, from one to five months following injury. Three were on Foster frames and one on a standard hospital bed. One patient required traction and head tongs. Early motivation for the rehabilitation program can be encouraged through self-feeding, giving the patient a feeling of some independence and satisfaction.

See also 748.

PARAPLEGIA—MEDICAL TREATMENT

See 758; 759.

PEDIATRICS

See 690.

PHYSICAL EDUCATION

742. Clarke, H. Harrison (*Univ. of Oregon, Salem, Ore.*)

Relationships in developmental and remedial physical education and corrective therapy. *J. Assn. Phys. and Mental Rehab.* May-June, 1959. 13:3:75-78, 96.

A comparison of developmental and remedial physical education, as practiced in schools and colleges, with corrective therapy, as used in hospitals and rehabilitation centers. The author traces briefly the common origins of both types of exercises and the historical backgrounds of each. Areas of differences are considered and the functions of developmental and remedial physical education in schools are defined, with suggestions for specific activities to be included to improve services for students with varying needs. Professional preparation for work in this field is discussed.

PHYSICAL EXAMINATIONS

743. McGee, Lemuel C. (900 N. Market St., Wilmington 1, Del.)

Some practical aspects of disability evaluation. *J. Occupational Med.* July, 1959. 1:7:387-390.

In disability evaluation, practical consideration must be given to the definition of terms, the legal implications, the true purpose of disability appraisal, to the anatomical, psychological, functional, and sociological factors, medical versus nonmedical factors, and to often unanticipated miscellaneous influences bearing on exceptional cases. The author discusses the many elements entering into disability determinations and the role of the physician in reporting disability. Advice is given on physician-patient relationships in disability cases. Disability evaluation is both a medical and an administrative responsibility.

PHYSICAL MEDICINE

744. Covalt, Nila Kirkpatrick (P.O. Box 1325, Winter Park, Fla.)

Physical medicine and rehabilitation; what it encompasses. *J. Am. Med. Women's Assn.* July, 1959. 14:7:585-590.

A general review of the preventive, diagnostic, treat-

ment, and training aspects of rehabilitation and physical medicine. Various diagnostic tests and modes of treatment in physical and occupational therapy are discussed, in an attempt to clear up some misconceptions concerning these forms of therapy. Dr. Covalt stresses that common errors and the improper use of therapy are deterrents to successful rehabilitation. The elements of a comprehensive program for the complete treatment of the physically disabled individual are outlined.

PHYSICAL THERAPY

745. Rood, Margaret

Neurophysiology in the treatment of neuromuscular dysfunction; ed. by Carol Moyer and Alvin J. Davis. Harrisburg, Pa., Pennsylvania Soc. for Crippled Children and Adults (1958?). 38 p. Mimeo.

Presented at Seminar for Physical, Speech, and Occupational Therapists, sponsored by the Wyoming Valley Crippled Children's Association and the Pennsylvania Society for Crippled Children and Adults, October 27-29, 1958.

Material based on lectures presented by Miss Rood at a three-day inservice training seminar. Demonstrations of specific technics for the activation, facilitation, and inhibition of muscle action through sensory receptors were used to show how normal motor patterns could be developed in the child. Two developmental sequences—for the vital functions (breathing and feeding, leading up to skills of speech) and for the skeletal muscles—are discussed in regard to procedures useful for progressive development.

Available from the Pennsylvania Society for Crippled Children and Adults, 1107 N. Front St., Harrisburg, Pa.

PSYCHOLOGY

See p. 266.

RECREATION

See 697.

REHABILITATION

746. Gordon, Edward E. (*Michael Reese Hosp., 29th and Ellis Ave., Chicago, Ill.*)

Chronic disease and disability; a public health responsibility. *Public Aid in Illinois.* May, 1959. 26:5:2-6, 12.

A paper presented at the 1958 Institute for Rehabilitation Workers, held at Southern Illinois University, Carbondale. Cited by the editor as a "clear and comprehensive statement of the need for help by those with chronic disability, the responsibility for that help, and the ways of supplying it," the article sketches the historic background of care for the handicapped, problems encountered in the rehabilitation of various types of disability, and the present needs for rehabilitation facilities, increased personnel, more public education, more comprehensive training in care of the chronically ill, and better financial support of programs. The Geriatric Rehabilitation Program in Illinois is offered as an illustration of cooperative efforts among existing resources to provide rehabilitation services for patients with chronic disability.

See also 698; 699.

ABSTRACTS

REHABILITATION—CALIFORNIA

747. California. Legislature. Joint Interim Committee on the Education and Rehabilitation of Handicapped Children and Adults

Report of the . . . 1959. Sacramento, Calif. State Senate, 1959. 284 p. tabs.

The current Joint Interim Committee has continued to study problems undertaken by Senate committees established in 1953 and 1955; this report is concerned with isolated problems falling within the scope of the resolution that established its purpose. Existing state policies pertaining to the education and rehabilitation of physically and mentally handicapped persons were analyzed, with particular consideration given to financial, administrative, professional, and legal problems involved in providing such services. Each chapter contains a summary of the findings and testimony given at hearings, as well as background information on the particular problem and the Committee's recommendations. Subjects under discussion were: the proposed establishment of a rehabilitation center for training and research, rehabilitation of the disabled and of industrially injured workers, workmen's compensation laws in relation to employment of the handicapped, special education, needs of the mentally retarded, sheltered workshops, day care centers for mentally retarded and physically handicapped children, the extension of Crippled Children Services, and two special progress reports on research projects. Appendixes include a wealth of information on legal provisions in California for such services as vocational rehabilitation, special education, mental health services, workmen's compensation, and state programs and services for the disabled.

Available from Joint Interim Committee of the California Legislature on Education and Rehabilitation of Handicapped Children and Adults, Room 701, 312 W. Fifth St., Los Angeles 13, Calif.

REHABILITATION—EQUIPMENT

748. Von Werssowetz, Odon F. (*Gonzales Warm Springs Foundation, P. O. Box 58, Gonzales, Texas*)

Early mobilization of the recumbent patient using a standing bed, by Odon F. Von Werssowetz and Marjorie Ruth Kirkpatrick. *Texas State J. Med.* July, 1959. 55:7:573-576.

Prolonged recumbency produces metabolic changes and causes circulatory decompensation and neuromuscular dysfunction in both the chronically ill patient and in those with short-term illness. The author advocates early standing to prevent or alleviate physiologic changes. For the patient who cannot stand voluntarily, the standing bed is of great benefit. Such a bed, as designed at the Texas Rehabilitation Center, combines a standard hospital bed with a standing device. It decreases the handling of the patient and can be operated by a single attendant. It has the added advantage of being both economical and comfortable. Rehabilitation centers include such beds as standard equipment; their use in the general hospital and home is also advocated.

REHABILITATION—SURVEYS

See 722.

REHABILITATION CENTERS—ADMINISTRATION

749. Covalt, Nila Kirkpatrick (*P. O. Box 1325, Winter Park, Fla.*)

Conference of Rehabilitation Centers; a report. *Arch. Phys. Med. and Rehab.* July, 1959. 40:7:293-299.

Reprinted from: *South. Med. J.* Nov., 1958. 51:11:1411-1416.

A report of the organization and growth of the Conference of Rehabilitation Centers, its activities, and policies; medical supervision and participation in rehabilitation centers is given special attention. The parallel growth of centers and curative or sheltered workshops is also discussed briefly.

750. Klapper, Morris (*Natl. Assn. for Mental Health, 10 Columbus Circle, New York 19, N. Y.*)

Sample survey of admission of ex-mental patients in rehabilitation centers. *Mental Hygiene.* July, 1959. 43:3:378-389.

Of 78 rehabilitation centers replying to a survey questionnaire, 38 indicated the existence of, or plans for, programs for exmental patients. Excerpts from correspondence or reports illustrate the actual range of such programs and the successful results achieved. Vocational services of a center are considered particularly beneficial for psychiatric patients. Although the survey sample was small, experiences of the centers quoted appear to indicate the possibility and desirability of including exmental patients in rehabilitation center programs. These patients can benefit from services, especially those of the sheltered workshop. The inclusion of psychiatric patients with those suffering other types of handicaps seemingly poses no particular problems. Lack of funds, however, is often responsible for the inability of rehabilitation centers to develop or expand services for mental patients.

751. U. S. Office of Vocational Rehabilitation

The operation of facilities and workshops by state vocational rehabilitation agencies; a report, by Robert E. Thomas. Washington, D. C., Off. of Voc. Rehabilitation, 1958. 56 p. tabs. (*Rehab. Serv. ser. no. 496*) Mimeo.

A description of the development of five multidisability centers established by state divisions of vocational rehabilitation in Virginia, West Virginia, Oklahoma, Pennsylvania, and Iowa. Since centers vary in size, organization, and service programs, they illustrate various ways of meeting the needs of clients of state agencies. Topics covered in each description include organization and management, history of the center, the physical plant, program of services, fees for services, disabilities served, staffing, operating costs, and community relations. Part I of the report gives an over-all view of facilities currently operated by State agencies, with data on types and number of facilities. The author's conclusions point out the elements common to all five centers, as well as their contributions to the total rehabilitation programs of the sponsoring state agencies.

Available from Henry Redkey, Consultant, Rehabilitation Facilities, U.S. Office of Vocational Rehabilitation, Washington 25, D.C.

RELIGION

See 729.

SOCIAL SERVICE—STUDY UNITS AND COURSES

See 692.

SPECIAL EDUCATION

See p. 266.

SPECIAL EDUCATION—CALIFORNIA

See 747.

SPECIAL EDUCATION—EUROPE

See p. 259.

SPECIAL EDUCATION—THE NETHERLANDS

752. Brown, Nora M. (*Univ. of Sheffield, Sheffield, Eng.*)

Special education in the Netherlands; 3. Unfamiliar categories. *Special Education*. May, 1959. 48:3:22-26.

A continuation of an article previously published in *Special Education*, describing provisions in the Netherlands (see *Rehab. Lit.*, June, 1959, #501). Categories of handicapped children discussed here are those having no counterpart in the English system of classification for special education purposes—children with tuberculosis, delinquent and deprived children, those in research institutes, children of migrant workers, and those with special learning or educational difficulties. A comparison of Dutch and English methods in meeting the educational needs of the various groups of handicapped children shows the advantages and disadvantages of the different systems of classification and technics. The concluding article in this series, to be published later, will discuss Dutch and English attitudes toward the problem of juvenile delinquency.

SPECIAL EDUCATION—SWEDEN

753. Sweden. Svenska Vanförevardens Centralkommitté

A few viewpoints on the care of handicapped children. *Information för Vanförevarden*. Mar., 1959. No. 2a. 8 p.

A brief survey of the facilities and resources in Sweden for medical care, special education, vocational training, and recreational programs for blind and partially sighted children, those with cerebral palsy, the deaf and hard of hearing, epileptic children, slow learners and mentally deficient children, and those who have chronic illnesses.

Available from Svenska Vanförevardens Centralkommitté, Ibsengatan 8-14, Bromma, Sweden.

SPINA BIFIDA—BIOGRAPHY

754. Goldberg, Diantha B. (*Central High School, Valley Stream, N.Y.*)

An unusual girl with spina bifida. *Am. J. Nursing*. July, 1959. 59:7:994-995.

Supportive help from the school nurse-teacher and the guidance provided by the family physician were responsible for the excellent adjustment made by a teen-age girl who was born with spina bifida in the cervical and lumbar regions. When she entered high school her handicaps consisted of a slightly unusual gait, feet that were small for her size, lack of ability to stand for long periods, and

urinary incontinence and frequency. The article relates how the school helped her to handle her health problems. Vocational counseling and handling of any emotional aspects of the girl's adjustment were provided by the nurse and physician.

SPORTS

755. Saywell, Stella (*Winford Orthopaedic Hosp., Bristol, England*)

Pony riding as a form of treatment for physically handicapped children and adults in Denmark and Norway. *News Rev.*, Central Council for the Care of Cripples (Gt. Brit.) Summer, 1959. p. 10-13.

An extract from a report by the superintendent physiotherapist at Winford Orthopaedic Hospital on her observations during a tour of Denmark and Norway. Pony riding as a form of treatment is provided by orthopedic hospitals, treatment centers, boarding schools, and voluntary organizations. Results in children with disability from various causes have been most encouraging. This form of treatment produces excellent balance and coordination of movement and results in greatly improved self-confidence and pride in accomplishment. All treatment should be prescribed by the physician and supervised by the physical therapist.

STUTTERING

756. Pierce, Chester M. (*Cincinnati Gen. Hosp., 3231 Burnet Ave., Cincinnati 29, Ohio*)

Stuttering; clinical and electroencephalographic findings, by Chester M. Pierce and Harry H. Lipcon. *Military Med.* July, 1959. 124:7:511-519.

A comparison of 36 stutterers with a similar number of nonstutterers among naval recruits was made in order to determine possible physiologic and psychologic causes of stuttering. Electroencephalographic tracing, neurological examination, history of symptomatic immaturity habits (enuresis, somnambulism), history of sickness, injury, and periods of unconsciousness, and handedness dominance were studied. The authors believe that stuttering is a syndrome in which psychological, social, and organic factors must all be considered. Among naval recruits there is some evidence that psychic stress both produces and sustains the habit of stuttering; among this group, however, it does not appear to be allied with other common immaturity habits such as enuresis and somnambulism. Literature on the subject is reviewed briefly; the theoretic and research aspects of stuttering are also considered.

SWIMMING

757. Padden, Donald A.

Ability of deaf swimmers to orient themselves when submerged in water. *Research Quart.*, Am. Assn. Health, Phys. Educ., and Recreation. May, 1959. 30:2:214-226.

An improvised test was used to determine the relationship of deafness to the sense of orientation when deaf subjects were submerged in water. Swimmers were classified in groups according to cause of deafness (congenital, meningitic, deaf from other causes, and deaf from unknown causes); they were given the test along with normal hearing swimmers. Findings of the study seem to indicate that in both phases of the test (eyes open and eyes blind-

folded) the meningitic group and poor balance group had considerably more difficulty in rising to the surface of the water; this does not imply, however, that these groups should be barred from swimming. Special attention should be given by the instructor to the meningitic group during the instructional period and while they are swimming for recreation.

Available in reprint form from *American Annals of the Deaf*, Gallaudet College, Washington 2, D.C., at 25¢ a copy.

UROLOGY

758. Bunts, R. Carl (300 Westoe Rd., Richmond 26, Va.)

Preservation of renal function in the paraplegic. *J. Urology*. June, 1959. 81:6:720-727.

In spite of the over-all improvement in management of paraplegics, urinary tract complications remain the major cause of death in these patients. From experience with and observation of several thousand paraplegics over a period of 10 years or more, the author discusses factors causing impairment of renal function, prophylactic and definitive treatment measures for preservation of renal tissue, and data from studies of renal function. 41 references.

759. Comarr, A. Estin (Rancho Los Amigos Hosp., Downey, Calif.)

The practical urological management of the patient with spinal cord injury. *Brit. J. Urology*. Mar., 1959. 31:1:1-46.

A discussion based on experience with patients with

traumatic paraplegia and quadriplegia at the V.A. Spinal Cord Injury Center, Long Beach, Calif. Day-to-day care as performed in the wards of the Center is described. Urological care, basically aimed at preservation of kidney function, stresses conservatism. Also discussed are urological first aid, indications for laminectomy, Bors' classification and neurological tests in diagnosis, urological tests to determine anatomical and functional conditions of the kidneys, diagnosis of the type of bladder, management of the bladder, the use of vesical mucosal anesthesia and nerve blocks, and urological complications and their management. General care and management of the patient after his discharge from the hospital are considered briefly. 53 references.

WHEEL CHAIRS

760. Fowles, Beth H. (Highland View Hosp., Harvard Rd., Cleveland 22, Ohio)

Evaluation and selection of wheel chairs. *Phys. Therapy Rev.* Aug., 1959. 39:8:525-529.

A supply of more than 100 wheel chairs is maintained in the physical therapy department of Highland View Hospital for use in evaluating patients' specific wheel chair needs. Three and one-half years' experience with 253 patients has demonstrated the need for a basic outline of procedures to be used in evaluation and selection. The outline included here covers objectives of evaluation, general and individual considerations in the selection of the chair, elements of the evaluation procedure, and modifications for chairs to be used by patients with specific disabilities. Trial periods for chairs may vary from one hour to one month.

(Continued from page 258)

violin with a bow; and a "blackout" cane, which had been used in England by Winston Churchill.

The story of the most famous cane associated with the medical profession appears in a book called "The Gold Headed Cane." This cane was the companion of five famous English doctors and was transferred from one to the other. The widow of the fifth owner presented the cane to the Royal College of Physicians in London, where it is preserved. It is a Malacca stick with a crossbar for its handle, and it is decorated with the coats of arms of the doctors who owned it.

American doctors in the past have had a professional rather than a personal relationship to walking canes. Many doctors in the last century kept a collection of canes in their offices for the purpose of circulating them among patients who required them. During the latter decades of the 19th century there lived, in a small village in Kentucky, a bearded, old-fashioned physician known in the community as "cane-toting Doc Smith." This appellation had been bestowed on him because he always had handy, in his small office as well as in his one-horse buggy,

a supply of courtesy canes, which were loaned to patients requiring their aid during convalescence.

There is also a story about a physician who lived in a midwestern city and had a great many talents, painting pictures, writing poetry, and playing several musical instruments. His very special hobby, however, eccentric though it may have been, was to wait for a heavy snow and then sally forth with his cane, drawing pictures in the snow for the amusement of the neighborhood children. There was another doctor who was a self-serving apothecary. He carried a cane with a gold head which contained a vial of ammonia and camphor, to be used in reviving women who fainted in public places.

Today's cane-minded doctor should find a new vista opening up when he considers the manifold uses to which a walking cane can be put. As its devotees know, the walking cane can be carried for sheer amusement rather than for actual support. For those who like to walk, the cane is a well-mannered companion, never talking back, but permitting its owner to entertain his hands as he reflects on the happenings of a busy medical day.

Events and Comments

New Information on Functional Homes for Handicapped

THE BOOKLET *A Functional Home for Easier Living*, issued by the Institute of Physical Medicine and Rehabilitation, New York City, serves as a guide for building or adapting a home for the physically disabled, the cardiac, or elderly. A "functional home" has doors that are wider than usual to allow easy passage of a wheel chair. The only door sills are at entrances and are recessed. Entrances have five-degree ramps and no steps. Doorknobs, window handles, light switches, and electric outlets are located and designed for easy use. For safety, floors are made of nonskid materials such as terrazzo with colored carborundum chips, preferably without carpeting or throw rugs. The kitchen has many energy-saving and storage features.

"Horizon Home," which follows the specifications given in the Institute's booklet, is one of eight models offered in the Florida retirement village of Skyview Homes, Pinellas Park, between Clearwater and St. Petersburg, Florida. This is a 1,200-home development, one of several such built by James Rosati and his sons during the last few years. Horizon Home has a living room, two bedrooms, kitchen, dining area, bathroom, and carport, all on one level, and sells for less than \$14,000. The booklet and additional information about the retirement village may be obtained by writing to Skyview Homes, U.S. 19 and 49th St. N., Pinellas Park, Florida.

As a contribution to the New York University-Bellevue Medical Center, Mr. Rosati is building a Horizon Home on the Center's grounds adjacent to the Institute. It will be used in training disabled homemakers and will be shown to visitors.

New Film Is Available on Aid for Deafness

A NEW FILM (16-mm., 29-min., sound, color) has been produced by the American Hearing Society through a \$31,000 grant from the U.S. Office of Vocational Rehabilitation. *The Glass Wall* tells a story of the effects impending deafness has on five persons, four of whom take advantage of services and are rehabilitated, while the other refuses aid, living on the lonely, silent side of a glass wall. Narration is by Paul Newman. Prints may be borrowed free of charge from the Society's headquarters at 919 18th St., N.W., Washington 6, D.C., for use at meetings or on television.

Dr. L. J. Evans to Coordinate Rehabilitation Services at N.Y.U.

DR. LESTER J. EVANS on November 1 will become director of the New York University Center for Rehabilitation Services, established in 1958 as the coordinating agency within the University. Dr. Evans is executive associate of the Commonwealth Fund. Carroll V. Newsom, president of the University, has stated that the Center was designed to "bring into focus the world's most comprehensive program for overcoming human disability."

Directory of U.S. Agencies for Handicapped Available

ACTIVITIES of 58 national and international organizations are briefly described and their publications listed in *Directory of Federal and Private Agencies Working with or for the Handicapped* (price 25¢). A roster of officers of the Committee for the Handicapped is also given. The directory was prepared by the Committee in cooperation with the President's Committee on Employment of the Physically Handicapped. Copies may be ordered from the Committee for the Handicapped, Executive Secretary, Room 205, 726 Jackson Pl., Washington, D.C.

Deceased

DR. BRONSON CROTHERS, 73, clinical professor of pediatrics at Harvard Medical School, died July 17th in Sorrento, Maine. Dr. Crothers, a pediatric neurologist, was the American pioneer in the treatment of cerebral palsy and was one of the six founding members of the American Academy for Cerebral Palsy.

The book *Natural History of Cerebral Palsy*, written by Dr. Crothers and Dr. Richard S. Paine, senior consultant in neurology, The Children's Hospital, Boston, is scheduled for publication this fall by the Harvard University Press.

DR. ARTHUR STEINDLER, 81, internationally known orthopedic surgeon, died July 21st in Iowa City, Iowa.

Recreation Magazine Giving Therapy of Ill and Disabled More Coverage

IT HAS BEEN ANNOUNCED by the National Recreation Association that two pages have been added to *Recreation Magazine* and will be devoted to articles and information in the field of recreational therapy for the ill and handicapped.

Research Activities of National Institutes of Health Reported

AMONG PUBLICATIONS now available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., are the following, all concerned with research activities of the National Institutes of Health: *Aging, a Review of Research and Training Grants Supported by the National Institutes of Health* (35¢); *The National Cancer Institute* (20¢); and *Highlights of Progress in Mental Health Research* (20¢).

New Managing Director of Industrial Medical Association Appointed

CLARK D. BRIDGES on May 1 was appointed Managing Director of the Industrial Medical Association, taking the place of Dr. Edward C. Holmblad, who retired. For the previous year and a half, Mr. Bridges was the Assistant Managing Director. His entire career has been devoted to the conservation of manpower and the prevention of disability. His book *Job Placement of the Physically Handicapped* (McGraw-Hill Book Co., 1946), though out of print, is still regarded as the standard reference on basic technics for matching disabled workers to suitable jobs with maximum effectiveness.

Postgraduate Training in Prosthetics Received by 382

DURING THE ACADEMIC year 1958-1959 in the prosthetics education program the New York University Post-Graduate Medical School trained 382 students. Sixty-three vocational counselors studied prosthetics and orthotics for rehabilitation personnel (4 courses offered). Sixty-two physicians and surgeons completed courses on the upper extremity (3 courses offered) and another 84 attended courses on above-knee prosthetics (four offered). Sixty-one therapists took courses on the upper extremity (4 offered) and 63 studied above-knee prosthetics (4 courses offered). Fourteen prosthetists completed courses dealing with the upper extremity (1 course) and 35 above-knee prosthetics (3 courses).

For information for the 1959-1960 academic year as to schedule, course content, admission requirements, tuition fees, living accommodations, and traineeships, write to Director, Prosthetics Education, NYU Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

PVA Surveys Adequacy of Colleges for Wheel-Chair Students

AN ARTICLE by Harry A. Schweikert, Jr., in the July, 1959, issue of *Paraplegia News* (p. 14-15) describes results of a questionnaire survey conducted by the Paralyzed Veterans of America to determine the physical adequacy for the handicapped of university and college grounds and buildings. The survey's specific purpose was to gather information on physical problems the wheel-chair student would meet, such as steps, narrow doorways, dining facilities, dormitories, lavatories, and steep grades. Of 162 questionnaires mailed to schools with 3,000 or more enrolled, 134 were returned. Four schools responded negatively; 13 with 280 wheel-chair students enrolled were considered adequate for such students; 38 with 120 enrolled appeared to offer limited use; and 79 with 27 such students enrolled were not adequate to a considerable degree. The article lists the schools by group.

Impairments in the United States During 1957-1958 Estimated

FINDINGS OF THE U.S. National Health Survey for the 12-month period ending with June, 1958, indicate that there were about 24 million impairments among the civilian residents of the United States not in institutions. The Survey estimates were derived from interviews, made during the year covered, in about 36,000 households comprised of 115,000 persons. Data in the report do not show the number of persons with impairments nor the extent to which those with one or more impairments may have had other chronic conditions. Of all impairments 33.0 percent were caused by injury—in males, 41.8 percent and in females, 22.2 percent. Impairment types having the highest proportions due to injury were absence of and other nonparalytic types of defects of the extremities. Speech defects and blindness were least often caused by injury.

For all impairments the rate per 1,000 persons was 141.4 for both sexes, 160.8 for males and 123.1 for females. The rates for conditions such as blindness and impairments of the spine, hip, and pelvis were higher for females; impairments due to injury had higher rates for the males in every category. With advancing age the rate of impairments increased, from 52.9 per 1,000 persons under 25 years of age to 615.0 per 1,000 at ages 75 and over. Persons of school and preschool age had a rate of 44.3 per 1,000; workers, 160.6; housewives, 174.4; retired persons, 560.0; and others, 348.6.

About one-tenth of the total impairments involved one or more bed-disability days in the year preceding the interview. All types of paralysis and impairments affecting the back and limbs involved more bed-disability days than the other types. (See *Rehab. Lit.*, Jan., 1959, p. 31, for résumé of the Survey's estimate of days of restricted activity for July-Sept., 1957.) Of all impairments, 82.2 percent had been seen by a physician. In

practically all cases, paralysis and absence of extremities had been medically attended. Least frequently tended were hearing defects, 68.1 percent, and speech defects, 59.3.

Between 12 and 13 million impairments were in some form of limited motion, including paralysis and other abnormalities in function, structure, or number of the bones, joints, or muscles of the limbs, back, and trunk. About 109,000 persons were totally deaf and about 5.7 million had some degree of hearing loss. There were about 960,000 instances of blindness (inability to read ordinary newsprint even with glasses) and 2,064,000 cases of other visual impairment. There were about 1,098,000 cases of speech defects. Included in a miscellaneous group of defects totalling 1,359,000 cases of impairments were abnormalities of structure of the face, jaws, and skull; mental retardation; deviation from normal body weight and size; and absence of organs and sites other than eyes and extremities. The report suggests that mental retardation, cerebral palsy, facial disfigurement, and absence of sites other than extremities may have been underreported.—*From Health Statistics from the U.S. National Health Survey: Impairments by Type, Sex, and Age, United States, July 1957-June 1958, U.S. Public Health Service, Washington, D.C. April, 1959. Available from U.S. Superintendent of Documents, Washington, D.C., at 25¢ a copy.*

Revised Catalog of Rehabilitation Aids and Self-Help Devices Available

A REVISED and enlarged edition of the Fascole sales catalog (Fascole Corp., 229 Fourth Ave., New York 3, N.Y.) is now available. It lists, with illustrations, equipment used in rehabilitation and personal and household aids for the disabled.

Toilet Hygiene

A NEW AUTOMATIC toilet seat has been developed that offers aid in toilet hygiene for those with hand disabilities, including paralytics, arthritics, and amputees. The seat uses a thermostatically controlled warm spray of water for a rectal wash.—*From AMA News, July 13, 1959.*

New Officials to Direct National Epilepsy League

MAURICE A. MELFORD has been appointed national director of the National Epilepsy League. He had been the League's public relations counsel since 1954. George N. Wright, Ph.D., named program director for the League, served with the Indiana Vocational Rehabilitation Division as a rehabilitation counselor for the past 11 years. He also formerly was a research fellow of the U.S. Office of Vocational Rehabilitation. Dr. Wright's graduate work was in psychology and guidance, his doctorate dissertation being "An Investigation of Problems Presented by Physically Handicapped Adults." He is presently writing a book on vocational counseling, which will be published by Harper Bros.

House Subcommittee to Study Needs of Handicapped

THE SUBCOMMITTEE on Special Education of the U.S. House of Representative's Committee on Education and Labor will study in detail special education and rehabilitation of physically and mentally handicapped persons. Interest will focus on the blind, deaf, speech defectives, homebound, cerebral palsied, and mentally handicapped persons. Objectives are to discover unmet needs and to suggest solutions for the most pressing, to analyze the adequacy of available services and to determine if services and agencies are duplicated or federal funds wasted, and to prepare legislation if needed to achieve these aims. Dr. Merle E. Frampton, Professor of Education, Hunter College, New York City, and Principal of the New York Institute for the Education of the Blind, is director of the study. Chairman of the Subcommittee is Rep. Carl Elliott of Alabama.

Paul F. Fleer Comments on Rehabilitation of Physically Handicapped in Nursing Homes

"A DEMONSTRATION rehabilitation project in nursing homes, currently being conducted in Green Bay by the Wisconsin State Board of Health, has shown clearly that 15 to 20 percent of physically handicapped nursing home residents can achieve significantly greater functional levels. A majority of these suffer from the great chronic cripples—strokes, hip fractures, and arthritis with the accompanying emotional factors of hopelessness, uselessness, and apathy."—*From "Rehabilitation of Physically Handicapped Residents in Nursing Homes," in Wis. Med. J., June, 1959, p. 315.*

The Beggar Problem in Ceylon

"MOST OF THE ASIAN countries have a considerable beggar problem to contend with. A report from Ceylon (*Report on the Beggar Problem in Ceylon*, Department of Social Services, Sessional Paper XI-1956, Government Publications Bureau, Colombo) on the topic is particularly interesting in that it also includes a chapter on the beggar situation and measures taken to combat it in other countries besides Ceylon. . . . In India there is one beggar for every 187 persons, whereas in Ceylon the proportion is only one to 4,000. Of the beggars of Ceylon, 43% are aged over 60. There is also a large proportion of physically or mentally handicapped, as well as a certain social group, the so-called low-caste beggars, who look upon begging as a birthright. In this last group there are, of course, some able-bodied men and women. The report shows clearly how the religious feelings of the populace are shrewdly exploited and also how begging can become a racket in which the crippled and handicapped are themselves exploited."—*From International Child Welfare Review, vol. 12, no. 4, 1958, p. 180.*

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